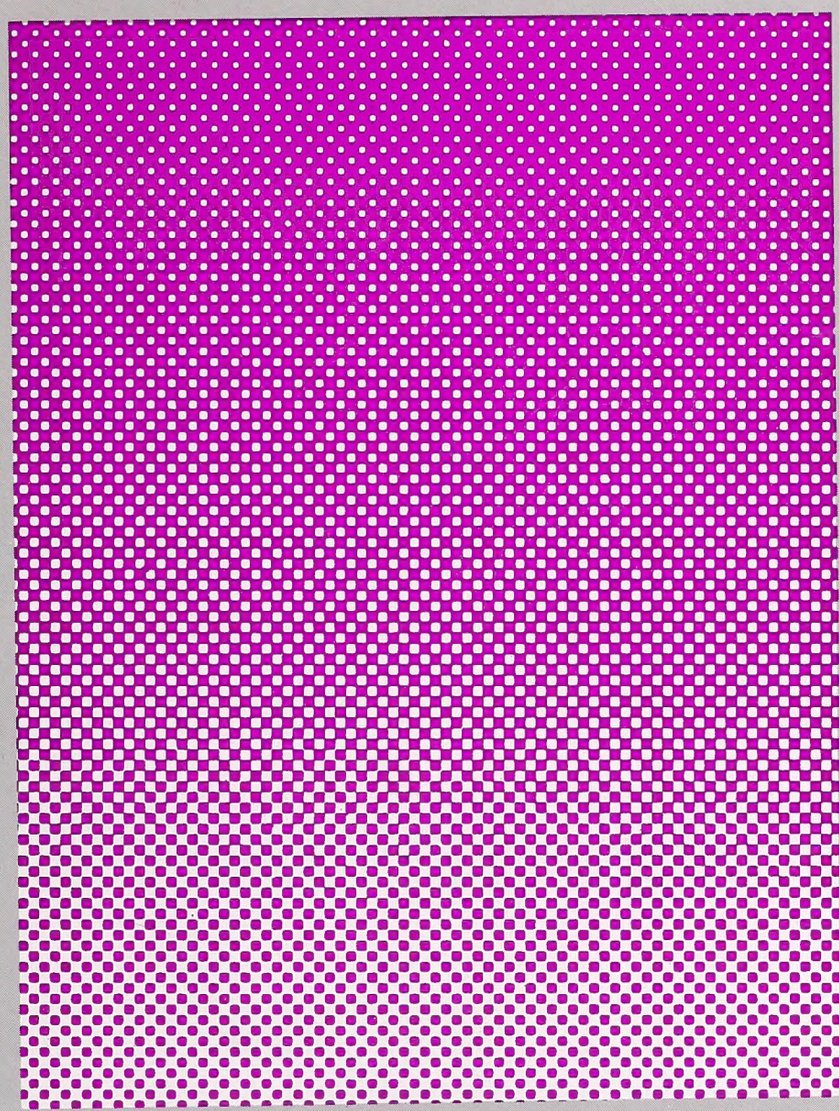
MEDICARE HOSPITAL MORTALITY INFORMATION



Volume II

Colorado - Illinois

U.S. Department of Health and Human Services
Health Care Financing Administration

RA981
.A2
M43
1986
v.2

MEDICARE HOSPITAL MORTALITY INFORMATION

1986

VOLUME II

COLORADO - ILLINOIS

OTIS R. BOWEN, M.D.
SECRETARY
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

WILLIAM L. ROPER, M.D.
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, D.C. 20402

The Health Care Financing Administration (HCFA) was established on March 9, 1977, to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Peer Review Organization program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to ensure the effective administration of our programs in order to promote the timely delivery of appropriate, quality health care to over 56 million of the nation's aged, disabled and poor. The agency must also ensure that beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that agency policies and actions promote efficiency and quality within the total health care delivery system.

Table of Contents
Volume II

Page

Introduction 1

Description of Information 3

Hospital Mortality Information—**Colorado** CO-1
Hospitals Commenting—**Colorado** CO-10

Hospital Mortality Information—**Connecticut** CT-1
Hospitals Commenting—**Connecticut** CT-6

Hospital Mortality Information—**Delaware** DE-1
Hospitals Commenting—**Delaware** DE-3

Hospital Mortality Information—**District of Columbia** DC-1
Hospitals Commenting—**District of Columbia** DC-3

Hospital Mortality Information—**Florida** FL-1
Hospitals Commenting—**Florida** FL-19

Hospital Mortality Information—**Georgia** GA-1
Hospitals Commenting—**Georgia** GA-15

Hospital Mortality Information—**Hawaii** HI-1
Hospitals Commenting—**Hawaii** HI-8

Hospital Mortality Information—**Idaho** ID-1
Hospitals Commenting—**Idaho** ID-6

Hospital Mortality Information—**Illinois** IL-1
Hospitals Commenting—**Illinois** IL-21

Technical Appendix
- Methodology i
- Summary v

The Administrator
Washington, D.C. 20201

INTRODUCTION

The nation's Medicare program, which is administered through the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, now has 31 million beneficiaries. One of HCFA's primary responsibilities is to ensure that Medicare beneficiaries receive quality health care. We believe that the publication of the information contained in this document will contribute to that end.

This particular information release, presents information to answer the question: "What is the actual death rate for each hospital compared to what would have been expected for that particular hospital given what we know of the characteristics of patients admitted?" The statistics are presented in the hope that they will serve the public and the hospitals in their common interest of improving quality of care.

The development of mortality statistics is a complicated and controversial task since the mortality rate at a given hospital reflects, among other factors, age, sex, diagnosis, and severity of illness of patients admitted to that hospital, as well as the purpose and quality of the care they received. Characteristics affecting health and the probability of death vary among the patient populations served by individual hospitals. Consequently, the mortality rates in different patient populations will vary.

The usefulness of this information depends upon the accuracy with which mortality rates can be predicted and the stability of these rates over time for each hospital. It is important to understand that the predicted values in the tables contained in this document are not a direct measure of the quality of care rendered in hospitals. There is one primary reason for this. We do not now have any direct measurement tool with which we can adjust fully for differences among hospitals in how severely ill their patients are. For instance, two hospitals might have very different death rates for patients admitted for stroke, even after we have adjusted for age and sex. This might happen because one hospital's stroke patients consist of a significant number admitted in a coma and are thus likely to die, whereas another hospital's patient population represents a broader spectrum of patients with cerebrovascular problems, or because these hospitals in fact provide different levels of quality. In addition, other factors affecting the probability of death in a particular case, e.g., family status/support, and overall health status are not included in the predictive model because information on them is not readily available.

When properly understood and used, this information can be useful; it can also be very misleading if it is interpreted incorrectly. The information simply describes one aspect of individual hospital performance--post admission mortality for Medicare beneficiaries. The information is not necessarily representative of a hospital's total performance in all aspects of patient care, and is best used to view experience in individual hospitals rather than making comparisons among hospitals. Individual hospitals may have very good reasons for their rates being higher than the ranges predicted by HCFA's model. Accordingly, it was important for hospitals to have an opportunity to review their specific information and to provide comments to HCFA and the public. We asked each hospital to prepare its comments on the information being released to the public, and we are including those comments in this publication.

The information is an important contribution to the health care community and should be reviewed by a wide range of individuals and organizations including hospital administrators, Peer Review Organizations, physicians and researchers. Among these audiences, perhaps the hospital administrator will find the information most useful--as a screening tool and in consulting with medical staff to evaluate a hospital's strengths and weaknesses. In this way, the information should lead to analysis and subsequent actions which will capitalize on areas of strong performance and strengthen areas where improvement is needed. For example, we expect that hospitals and their medical staffs, using established and newly emerging quality assessment techniques, will try to determine what useful information can be derived about how they function.

Consumers should read the explanations of the uses and limitations of the information, as well as any comments a hospital may have provided, and should carefully consider the different roles that different hospitals play in their community. For example, one hospital might have different death rates than another because it serves more severely ill patients, because it specializes in difficult illnesses, or because it is a trauma or emergency center.

The development and presentation of this information is an important part of HCFA's responsibilities in the health care community, and follows nearly a full year of effort. In making the information as accurate and useful as possible, we discussed the theoretical framework and statistical approach with a number of national experts in appropriate fields. As a result, we believe the models used in this work are reasonable and appropriate for the intent of the publication. In addition, the format for presentation, the process for sharing the information with individual hospitals, and the statistical methodology have been discussed at a series of meetings with leaders of organizations representing Medicare beneficiaries, doctors and hospitals, and a great many suggestions from these groups have been incorporated into the final approach.

We are continuing to do everything we can to make these types of information more useful to both the public and the health care professions. We are refining ways to use the information as a screening tool for "quality of care" purposes, and we are developing tools to adjust for the differences in disease severity highlighted earlier. In addition, because we recognize that mortality rates alone do not adequately measure how effectively a hospital cares for its patients, we will be developing other measures of outcome, such as the kind of medical treatment needed after discharge, to assess the performance of hospitals more fully.

We have begun what will be a continuing effort involving all interested parties to improve the accuracy of outcome predictions by refining the model and the methodology. This will contribute to assessment of and improvement in the effectiveness of medical services.

William L. Roper M.D.

William L. Roper, M.D.
Administrator

DESCRIPTION OF INFORMATION

Before reading the tables containing the hospital specific information and the comments provided by individual hospitals, it would be useful to understand the format and presentation of the information in this document.

The information is presented in alphabetical order by state and by hospital within the state. For each hospital, information is presented for overall Medicare patient mortality and each of 16 diagnostic categories. The information consists of the number of Medicare patients, the actual mortality rate, and a range of predicted mortality given the mix of patients. It would be helpful to describe how the numbers were derived and what they represent.

- Number of Patients. This figure represents the number of individual Medicare beneficiaries whose last discharge from a short term, acute care hospital in 1986 was from the hospital listed. The total number for each hospital is presented under the category "overall." Similarly, for each diagnostic category, the number of patients consists of the number of Medicare beneficiaries whose last discharge in 1986 was from the hospital cited and whose primary diagnosis fell within the specific diagnostic category. (Generally the number of patients in the sixteen diagnostic categories will total between 70 percent and 80 percent of the figure for "overall." The remaining 20 percent to 30 percent represent diagnoses that do not fall within the 16 diagnostic categories specifically studied.)

  Since only a patient's last hospital discharge is "counted" in the total number, HCFA's computation and that maintained by individual hospitals will generally differ. For example, if John Doe was a patient at Hospital A three times during 1986, the methodology used in HCFA's analysis counts only the last admission in the hospital's total. Normally a hospital will maintain statistics based on numbers of admissions and so would count Mr. Doe as three cases. In addition, in this example, if Mr. Doe were admitted later in the year to Hospital B (another acute care hospital) and then discharged in 1986, and this latter stay represented his last discharge for 1986, his case would be counted in Hospital B's total and he would not appear at all in Hospital A's count.

  The key factor to remember is that we are examining last hospital discharges in 1986. In some cases, this will necessitate the inclusion of patients admitted to the hospital in December 1985 or those who died in January 1987.

- Actual Mortality Rate. This figure presents the percentage of each hospital's Medicare patients who died within 30 days of the admission that resulted in the last-occurring discharge of the patient in 1986. (The percentage is rounded to the nearest whole percentage point.)

  Where, for example, Hospital A had a universe of 1000 patients whose last acute care hospital discharge in 1986 was from Hospital A, and 100 of these patients died within 30 days of that last admission, whether as hospital inpatients or after discharge, the actual mortality rate would be 10 percent. This rate includes cases in which a beneficiary was admitted to the hospital in 1985, was discharged in 1986 and died within 30 days of admission. It also includes those instances in which a beneficiary was discharged in 1986 and died within 30 days of admission even though the 30 day period extends into 1987. Cases in which the beneficiary was not discharged in 1986

are not part of the rate, even though an individual may have died in 1986 or have died within 30 days of last hospital admission. For example, a person admitted to a hospital on December 20, 1985, who was discharged on December 30, 1985 and whodied on January 2, 1986 is not part of the calculation since the person was not discharged in 1986. Similarly, a person admitted to a hospital on December 28, 1986 who was discharged on January 5, 1987 and died on January 8, 1987 would not be a part of the calculation even though he or she died within 30 days of a 1986 admission.

- Range of Predicted Mortality. This column gives an estimate of mortality rates for patients equal in number and similar in characteristics to those treated by the hospital. The range is derived in part by determining, based on national experience, the relative risk of dying associated with various patient characteristics: previous hospital admission(s), transfer status, age, sex, and presence of up to eight comorbid conditions (cancer, cardiovascular disease, cerebral degeneration/psychosis, pulmonary disease, renal disease, liver disease, diabetes, hypertensive disease) and by applying weights of the risk factors to the actual number of patients at the hospital to enable compilation of an expected mortality rate. This rate is converted, through statistical techniques, to a range of predicted mortality rates. It is important to note that the fewer the number of cases included in a given diagnostic category, the greater the uncertainty of the expected mortality range, and therefore, the wider the range. A larger number of cases yields greater precision, and therefore, a more narrow range of predicted mortality rates.

HOSPITAL COMMENTS

On September 21, 1987, HCFA mailed to each hospital its own mortality information and asked for comments by October 28, 1987. These comments are arranged alphabetically by state and are included in this publication immediately after the tables presenting information for all the hospitals in a given state. The entry for each hospital on the state charts indicates where to find the hospital's comments and presents a notation (asterisk) advising of the absence of hospital comments. The page number where the comments of the hospital are presented is given next to the name and address of the hospital.

The comments are generally reproduced as submitted by the hospital. However, some hospitals returned to HCFA, an annotated copy of the information sent on September 21. These annotated materials have not been reproduced in this publication, even in those instances where they were the only form of comments submitted by a hospital. The reason for not printing these materials is one of privacy. Information which would identify or possibly identify patients must be deleted, and consequently any remaining information would be very confusing and of extremely limited use, if not totally useless. Therefore, we have included a statement to identify instances when these types of materials have not been included. As mentioned earlier, it is extremely important that the information presented in the tables be reviewed in concert with the hospital's comments.

In any project of this size, there will be instances where hospitals did not receive the information for comment or did not receive it timely. In fact, many hospitals were sent second copies of their specific information in an expeditious manner to allow every opportunity for review/study and comment. Although we have received over 2,600 comments out of a possible 5,971, it is possible that some of the non-responding facilities never got the information or did not have adequate time to comment. However, we expect these instances were few in number.

INFORMATION SOURCES AND NOTES

It is important to note that this publication is based primarily on analysis of Medicare hospital billing information for calendar year 1986. While information about beneficiaries, was obtained from the Social Security Administration (SSA), the principal source for the analysis was the HCFA maintained MEDPAR file which contains information about each Medicare hospitalization. Hospitals submit such information to HCFA's fiscal intermediaries (which pay hospitals for the care provided to Medicare beneficiaries). The file is updated quarterly. It is estimated that billing information on approximately 95% of all Medicare discharges is included in the MEDPAR file within 6 months of the close of the calendar year. Accordingly, our analysis was based on information received through June 30, 1987.

In any large scale data base such as one dealing with Medicare hospitalizations, there will be gaps or inaccuracies. The fact that the files contain information on about 10 million hospital admissions to nearly 6,000 hospitals provides some assurance that for purposes of the statistical analysis conducted here, the information which might be missing or inaccurate is such a small portion of the total that it would have almost no impact on the results.

Nonetheless, while we feel that the information used in this analysis is quite thorough and complete, there are a few points which should be kept in mind as the hospital specific information is being reviewed.

- The information used is billing data and is only as good as the information submitted by hospitals as a part of the payment process. Although there is always a possibility that coding errors are included, the assumption is that hospitals do not make errors on billing forms which ultimately affect payment to them. Likewise, it is assumed that given the link to payment, hospitals have an incentive to submit bills promptly.

- The hospitals included in this analysis are short-term, acute care facilities which were identified by their unique provider number. All facilities which have a zero in the third column of their provider number are by definition participating in Medicare as short-term, acute care facilities. All other facilities--those with something other than a zero in the third column of the provider number--were excluded from the analysis. In some cases, hospital names suggest an orientation different from acute care. This does not mean the facility is inappropriately included in the publication.

- There is some information in the file which does not reflect the results of review by Peer Review Organizations (PROs), the entities charged with reviewing hospital services provided to Medicare beneficiaries. For example, one of the functions a PRO performs is to ensure that the diagnosis assigned to a particular case is accurate. The nature of the review and payment system is such that it is possible for PRO changes in diagnosis assignment not to be submitted to HCFA and associated in the MEDPAR file on as timely a basis as other billing information. Obviously, any major changes in diagnosis assignment which are not reflected in the data base would have a bearing on calculation of mortality rates in individual diagnostic categories and may also have a bearing on the extent to which presence or absence of comorbidities has been reflected accurately.

Some hospitals pointed out instances where the hospital's information did not agree with HCFA's, e.g., different date of death, cases of subsequent admission to another facility, or changes in diagnosis codes. The data base used in this analysis has not been revised to reflect these potential discrepancies. Rather we are examining all hospital comments to ensure that changes to our data systems and processes can be made when warranted so that future releases will be even more accurate. Readers are urged to review any hospital comments with a specific view toward these types of issues.

- The predictive model used in this effort does not explain all variability in outcome. Most notably, a measure of severity of illness has not been included in the model, and therefore, the predictive power of the model is less precise than it would be if such a measure had been available. Nonetheless, the information included in this document does legitimately contribute to the body of information about hospital performance.

Colorado

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALAMOSA COMMUNITY HOSP ALAMOSA CO 81101	CO-9 *	286	10	8-17	12	8	8-55	11	27	8-58	16	13	4-42	19	11	7-43	12	33	15-66	7	14	3-62	24	17	8-41
AMC CANCER RESEARCH CENTER LAKEWOOD CO 80214	CO-10	28	46	11-43	7	71	10-72				3	67	4-84							2	50	4-92			
ARKANSAS VALLEY REGIONAL M LA JUNTA CO 81050	CO-11 *	649	12	9-17	26	12	8-41	25	20	15-50	27	15	6-37	46	26	11-35	30	60	25-60	20	0	4-39	69	14	11-31
ASPEN VALLEY HOSPITAL ASPEN CO 81611	CO-12	79	[illegible]	5-21	3	33	4-85	4	25	5-79	3	0	0-82	6	17	4-67	4	25	6-80	2	0	0-91	7	0	3-60
BETH ISRAEL HOSP DENVER CO 80204	CO-13 *	1264	16	11-18	84	20	12-33	43	30	20-48	36	22	9-37	74	28	14-34	32	19	23-56	30	27	10-42	219	26	19-33
BOULDER COMMUNITY HOSP BOULDER CO 80301	CO-14	989	11	9-16	76	13	12-34	30	53	12-43	19	16	6-43	51	6	12-35	46	37	26-55	20	10	6-43	110	11	12-29
BOULDER MEMORIAL HOSPITAL BOULDER CO 80302	CO-15	463	6	6-14	31	16	8-38	8	13	9-66	6	17	1-63	17	12	9-49	9	0	15-72	13	15	3-46	30	7	7-36
CLAGETT MEMORIAL HOSPITAL RIFLE CO 81650	CO-16 *	114	20	9-24	4	75	5-80	6	0	5-69	3	33	0-82	[illegible]	50	7-64	7	29	10-71	4	50	2-75	27	11	10-42
COMMUNITY HOSPITAL GRAND JUNCTION CO 81501	CO-17 *	429	10	8-17	23	9	8-43	13	23	11-59	15	7	3-41	16	25	8-49	16	44	22-68	12	0	2-47	48	27	10-34
CONEJOS COUNTY HOSP LA JARA CO 81140	CO-18 *	142	13	9-22	4	75	4-78	9	44	7-61	7	0	1-58	8	0	6-62	4	75	6-81	3	0	0-83	31	13	9-39
CRAIG HOSPITAL ENGLEWOOD CO 80110	CO-19 *	3	0	0-99																					
DELTA CO MEMORIAL HOSP DELTA CO 81416	CO-20	518	7	8-16	31	10	8-39	6	0	7-72	11	0	2-48	12	33	6-51	29	31	23-57	3	0	0-83	61	11	12-33
DENVER GENERAL HOSPITAL DENVER CO 80204	CO-21	739	11	7-15	32	25	16-48	18	44	9-48	18	22	5-43	42	17	10-35	24	54	22-61	23	26	5-38	78	23	8-27
EAST MORGAN COUNTY HOSP BRUSH CO 80723	CO-22 *	147	15	9-21	5	20	3-71	7	14	8-69	4	50	3-76	11	45	8-57	5	60	9-79	5	40	4-72	25	12	6-37
EISENHOWER MEDICAL CENTER COLORADO SPRINGS CO 80909	CO-23 *	427	12	7-15	21	29	8-44	15	40	12-56	15	33	5-45	18	22	9-48	4	0	9-85	9	11	6-61	44	25	10-35
ESTES PARK MED CTR ESTES PARK CO 80517	CO-24 *	127	8	5-17	6	0	1-63	1	100	0-97	4	0	1-74	5	0	3-70	6	50	16-82	2	0	1-89	17	0	4-40
FAMILY HEALTH WEST FRUITA CO 81521	CO-25 *	45	24	9-32	2	50	1-89	3	33	5-86	2	50	1-89				1	0	2-98				11	9	5-52
FITZSIMMONS GEN HOSP DENVER CO 80240	CO-26 *	1	0	0-100																					
FORT MORGAN COMMUNITY HOSP FORT MORGAN CO 80701	CO-27 *	247	19	8-18	13	54	7-52	10	70	8-60	7	0	1-58	12	33	8-56	14	50	18-65	11	9	3-50	18	22	7-45
GUNNISON VALLEY HOSPITAL GUNNISON CO 81230	CO-28 *	72	13	5-21	2	0	0-89	2	50	2-90	2	50	1-89	8	38	5-61	3	0	5-85	1	100	0-98	6	0	1-62
HAXTUN HOSPITAL DISTRICT HAXTUN CO 80731	CO-29 *	53	6	7-27	1	0	1-97	2	0	1-89	3	[illegible]	0-83	3	0	2-81	2	0	3-91	4	25	4-78	9	22	8-62
HIGHLANDS CENTER HOSP DENVER CO 80214	CO-30 *	41	[illegible]	0-61																					
HORIZON HOSPITAL DENVER CO 80218	CO-31 *	18	0	0-36																					
HUERFANO COUNTY HOSP AND M WALSENBURG CO 81089	CO-32 *	135	15	12-27	4	75	2-75	6	33	9-74	5	20	0-72	9	11	7-60	5	60	12-83	3	0	2-82	41	15	15-43
HUMANA HOSPITAL - MOUNTAIN THORNTON CO 80229	CO-33	779	12	8-16	38	26	11-40	25	24	15-50	21	19	5-39	54	26	14-38	29	45	22-57	20	0	3-38	94	19	11-29
HUMANA HOSPITAL AURORA AURORA CO 80012	CO-34	660	9	7-14	49	12	13-39	20	25	13-52	16	[illegible]	4-42	22	18	8-43	21	33	20-60	27	26	5-36	44	9	9-33

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALAMOSA COMMUNITY HOSP ALAMOSA CO 81101	2	0	1-90	2	50	2-90	12	0	1-43	1	0	0-100	40	0	1-17	4	25	1-74	4	25	0-100	23	9	1-26	12	0	0-44
AMC CANCER RESEARCH CENTER LAKEWOOD CO 80214	.	.		.	.		.	.		.	.		.	.		2	0	1-89	.	.		.	.		1	0	0-98
ARKANSAS VALLEY REGIONAL M LA JUNTA CO 81050	8	25	9-70	9	33	11-68	21	5	2-30	.	.		87	5	1-12	25	4	1-26	9	0	0-100	85	5	2-12	13	0	0-76
ASPEN VALLEY HOSPITAL ASPEN CO 81611	.	.		.	.		5	0	0-79	.	.		9	0	0-54	2	0	0-99	.	.		3	0	0-98	9	0	0-99
BETH ISRAEL HOSP DENVER CO 80204	11	45	8-62	7	57	16-80	58	5	6-24	2	50	0-100	124	8	3-12	73	10	2-17	6	0	0-100	87	3	2-13	66	6	1-12
BOULDER COMMUNITY HOSP BOULDER CO 80301	11	36	7-60	8	63	17-77	32	19	2-24	1	0	0-100	111	5	2-11	49	4	1-18	23	0	0-82	70	6	1-12	59	3	0-12
BOULDER MEMORIAL HOSPITAL BOULDER CO 80302	1	0	1-97	3	33	12-93	16	13	1-35	15	0	0-87	35	6	2-21	9	11	0-51	1	0	0-100	21	0	0-27	59	2	0-12
CLAGETT MEMORIAL HOSPITAL RIFLE CO 81650	1	100	1-97	1	0	0-97	2	0	0-99	.	.		10	0	0-54	1	0	0-100	.	.		6	0	0-71	5	0	0-99
COMMUNITY HOSPITAL GRAND JUNCTION CO 81501	4	25	6-82	9	11	11-68	14	0	1-38	2	0	0-100	37	14	2-20	34	6	1-21	8	0	0-99	28	7	1-23	46	0	0-17
CONEJOS COUNTY HOSP LA JARA CO 81140	4	50	5-81	3	0	6-88	5	0	0-70	1	0	0-100	18	0	0-31	4	0	0-81	1	0	0-100	2	0	0-99	8	0	0-67
CRAIG HOSPITAL ENGLEWOOD CO 80110	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
DELTA CO MEMORIAL HOSP DELTA CO 81416	2	50	4-92	13	31	18-68	15	7	1-37	4	0	0-100	67	1	1-13	31	0	0-23	10	0	0-100	54	4	1-15	51	0	0-14
DENVER GENERAL HOSPITAL DENVER CO 80204	3	33	0-83	11	36	14-67	30	7	3-28	1	0	0-100	48	0	2-17	28	0	1-25	7	0	0-100	39	5	1-18	28	0	0-22
EAST MORGAN COUNTY HOSP BRUSH CO 80723	5	0	2-71	.	.		12	8	2-43	.	.		19	0	1-30	1	0	0-100	3	0	0-100	6	0	0-78	3	0	0-97
EISENHOWER MEDICAL CENTER COLORADO SPRINGS CO 80909	12	8	7-58	5	40	7-77	12	17	1-42	1	0	0-100	60	7	1-14	27	11	1-25	4	0	0-100	28	4	1-23	42	0	0-20
ESTES PARK MED CTR ESTES PARK CO 80517	1	0	0-97	.	.		1	0	0-99	.	.		14	0	0-39	5	20	0-76	1	0	0-100	14	0	0-38	3	0	0-100
FAMILY HEALTH WEST FRUITA CO 81521	.	.		5	60	10-80	1	0	0-100	.	.		.	.		3	0	0-83	.	.		1	0	0-100	3	0	0-100
FITZSIMMONS GEN HOSP DENVER CO 80240	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
FORT MORGAN COMMUNITY HOSP FORT MORGAN CO 80701	2	0	3-91	2	100	3-92	14	14	2-40	.	.		34	9	1-21	3	0	0-99	3	0	0-100	29	3	1-22	15	0	0-44
GUNNISON VALLEY HOSPITAL GUNNISON CO 81230	1	0	0-98	.	.		2	0	0-95	.	.		5	0	0-79	2	50	0-92	2	0	0-100	2	0	0-100	5	0	0-100
HAXTUN HOSPITAL DISTRICT HAXTUN CO 80731	1	0	0-99	.	.		2	0	0-94	.	.		4	0	0-95	1	0	0-100	.	.		9	0	0-57	2	0	0-99
HIGHLANDS CENTER HOSP DENVER CO 80214	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		35	0	0-36
HORIZON HOSPITAL DENVER CO 80218	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
HUERFANO COUNTY HOSP AND M WALSENBURG CO 81089	4	25	7-82	2	0	1-89	1	0	0-99	.	.		11	9	1-44	2	0	0-99	2	0	0-100	10	10	0-47	1	0	0-100
HUMANA HOSPITAL - MOUNTAIN THORNTON CO 80229	7	14	7-70	10	20	11-66	17	18	2-36	1	0	0-100	80	6	2-14	24	4	0-27	5	0	0-100	74	3	2-13	54	2	0-14
HUMANA HOSPITAL AURORA AURORA CO 80012	6	17	3-67	2	0	2-90	25	8	2-28	1	0	0-100	58	7	1-14	42	5	1-19	10	0	0-100	51	8	1-16	63	2	0-11

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
KIT CARSON COUNTY MEMORIAL BURLINGTON CO 80807	CO-35 *	103	17	10-25	6	67	8-73	5	40	7-76	3	67	1-81	4	25	2-74	7	43	16-79	4	25	3-77	24	8	6-38
KREMMLING MEMORIAL HOSPITA KREMMLING CO 80459	CO-36 *	81	5	6-22	3	0	1-81	7	0	9-70	.	.		7	0	3-61	2	100	4-93	2	0	0-94	14	0	3-44
LAPLATA COMMUNITY HOSPITAL DURANGO CO 81301	CO-37 *	253	14	8-18	15	33	10-54	7	57	6-65	10	10	3-52	13	31	6-49	5	60	9-79	9	22	4-56	30	10	8-38
LINCOLN COMMUNITY HOSPITAL HUGO CO 80821	CO-38	70	13	9-27	2	0	6-94	3	0	2-82	4	50	4-78	3	33	2-82	7	57	11-73	4	0	3-76	11	9	3-48
LOGAN COUNTY HOSPITAL STERLING CO 80751	CO-39	461	15	9-18	36	19	12-42	19	32	14-54	13	23	6-51	21	24	9-44	18	44	22-66	7	29	3-61	50	38	10-33
LONGMONT UNITED HOSPITAL LONGMONT CO 80501	CO-40 *	1176	10	8-15	77	17	13-34	28	18	14-47	33	15	8-36	56	14	11-33	37	49	24-56	37	22	9-37	102	19	12-29
LUTHERAN HOSP AND MED CTR WHEAT RIDGE CO 80033	CO-41	3169	10	8-14	236	15	15-30	70	29	19-41	84	11	9-29	122	30	16-31	105	32	28-48	68	16	9-31	279	16	14-26
MCKEE MEDICAL CENTER LOVELAND CO 80537	CO-42 *	987	12	8-15	73	30	14-37	30	37	16-49	27	22	7-38	31	23	11-40	46	48	25-54	17	6	4-42	98	15	11-28
MELISSA MEMORIAL HOSPITAL HOLYOKE CO 80734	CO-43	60	13	8-28	3	0	0-83	2	0	2-90	2	0	0-92	5	40	5-73	4	50	9-84	.	.		7	0	3-60
MEMORIAL HOSPITAL COLORADO SPRINGS CO 80909	CO-44 *	1236	9	7-14	67	16	11-34	33	30	16-47	24	38	6-39	66	18	13-33	59	31	22-48	27	7	7-39	80	20	12-31
MEMORIAL HOSPITAL CRAIG CO 81625	CO-45	115	10	6-20	4	50	2-75	5	40	7-76	2	50	1-89	3	0	3-83	2	0	5-93	4	0	1-75	18	6	7-45
MEMORIAL HOSPITAL OSTEO GREELEY CO 80631	CO-46 *	10	10	1-47	1	0	0-99	.	.		.	.		.	.		.	.		.	.		1	0	0-99
MERCY MEDICAL CENTER DENVER CO 80206	CO-47 *	1694	11	8-15	115	30	18-37	43	23	17-44	32	22	6-35	73	25	15-35	48	33	25-53	23	17	4-37	178	20	14-28
MERCY MEDICAL CENTER OF DU DURANGO CO 81301	CO-48 *	635	9	8-15	40	25	10-37	18	39	11-51	23	9	4-36	18	17	8-46	18	33	18-61	12	8	4-50	75	11	14-34
MONTE VISTA COMMUNITY HOSP MONTE VISTA CO 81144	CO-49 *	133	17	9-23	6	50	8-74	3	0	5-85	2	0	0-90	7	29	4-62	10	60	12-66	6	33	5-69	21	14	9-45
MONTROSE MEMORIAL HOSP MONTROSE CO 81401	CO-50 *	589	9	8-16	40	28	9-36	16	25	11-53	20	10	6-41	22	18	10-45	31	16	23-57	14	7	3-45	40	15	13-40
MOUNT SAN RAFAEL HOSP TRINIDAD CO 81082	CO-51 *	255	12	10-21	13	31	8-54	14	7	11-56	9	11	4-56	15	7	7-48	12	25	18-69	2	0	2-90	46	11	10-34
NORTH COLORADO MEDICAL CTR GREELEY CO 80631	CO-52 *	2302	11	8-14	188	25	16-33	41	27	15-43	60	20	9-31	61	20	13-35	73	45	26-50	30	7	4-33	205	23	12-25
PARKVIEW EPISCOPAL MED CTR PUEBLO CO 81003	CO-53 *	1322	11	8-15	106	25	16-35	49	37	15-40	23	17	6-39	49	14	12-36	49	31	23-51	23	17	6-40	120	26	12-28
PENROSE HOSPITAL COLORADO SPRINGS CO 80907	CO-54 *	2914	10	8-14	228	24	16-32	60	33	19-43	52	6	9-33	87	24	15-33	95	41	28-49	58	5	8-31	198	20	13-26
PIONEERS HOSP OF RIO BLANC MEEKER CO 81641	CO-55 *	30	23	6-34	.	.		1	100	2-98	.	.		2	100	1-89	1	0	1-97	.	.		12	33	8-55
PIONEERS MEMORIAL HOSPITAL ROCKY FORD CO 81067	CO-56 *	19	37	8-44	1	100	0-99	4	50	3-76	.	.		2	50	1-89	1	100	2-99	2	0	1-89	5	40	2-69
PLATTE VALLEY MEDICAL CTR BRIGHTON CO 80601	CO-57 *	389	11	9-18	15	27	5-46	9	44	9-64	12	8	2-45	27	7	11-43	15	20	20-67	18	17	3-39	77	23	12-32
PORTER MEMORIAL HOSPITAL DENVER CO 80210	CO-58	2885	11	8-15	200	27	19-35	49	27	17-43	61	16	9-31	129	16	15-30	120	32	29-49	68	16	9-32	251	22	14-26
POUDRE VALLEY MEMORIAL HOS FORT COLLINS CO 80521	CO-59	1847	11	8-15	133	26	17-35	56	38	18-43	44	14	9-34	64	22	13-35	72	38	28-52	42	5	7-33	155	18	13-28
PRESBYTERIAN DENVER HOSPIT DENVER CO 80218	CO-60 *	3001	12	9-15	245	21	17-33	75	28	20-42	95	12	11-30	105	18	16-34	94	48	30-51	62	24	12-36	238	25	15-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
KIT CARSON COUNTY MEMORIAL BURLINGTON CO 80807	1	0	0-97	1	0	2-98	.	.		.	.		12	0	0-53	2	0	0-94	.	.		9	11	0-50	6	0	0-94
KREMMLING MEMORIAL HOSPITA KREMMLING CO 80459	1	0	0-100	1	0	2-98	.	.		.	.		9	0	0-53	2	0	0-96	.	.		14	0	0-39	2	0	0-100
LAPLATA COMMUNITY HOSPITAL DURANGO CO 81301	1	0	0-98	3	67	4-84	3	0	0-84	.	.		23	0	1-26	13	0	0-63	2	0	0-100	12	8	1-41	8	0	0-84
LINCOLN COMMUNITY HOSPITAL HUGO CO 80821	2	50	2-91	.	.		.	.		.	.		2	0	0-98	.	.		2	0	0-100	9	0	0-50	2	0	0-100
LOGAN COUNTY HOSPITAL STERLING CO 80751	5	20	10-82	4	0	6-81	21	10	2-31	4	0	0-100	53	8	2-17	38	3	0-20	6	0	0-100	19	0	1-30	42	5	0-16
LONGMONT UNITED HOSPITAL LONGMONT CO 80501	7	29	6-69	8	13	11-71	43	16	4-25	5	0	0-100	113	6	3-13	41	2	1-19	9	0	0-94	122	5	2-10	127	2	0-7
LUTHERAN HOSP AND MED CTR WHEAT RIDGE CO 80033	21	19	9-50	25	40	20-59	63	21	4-20	19	0	0-76	325	6	3-8	130	3	2-12	51	0	0-24	182	7	3-10	265	2	0-4
MCKEE MEDICAL CENTER LOVELAND CO 80537	4	0	0-81	15	47	16-64	34	15	2-23	3	0	0-100	109	4	2-12	50	0	1-17	16	0	0-98	96	7	2-12	91	2	0-8
MELISSA MEMORIAL HOSPITAL HOLYOKE CO 80734	2	0	1-90	1	0	0-97	3	33	2-81	.	.		5	0	0-70	7	0	0-64	.	.		2	50	0-90	3	0	0-99
MEMORIAL HOSPITAL COLORADO SPRINGS CO 80909	9	0	3-58	5	0	9-80	37	0	1-21	9	0	0-100	138	5	2-10	42	0	1-19	18	0	0-88	180	3	2-9	99	2	0-8
MEMORIAL HOSPITAL CRAIG CO 81625	2	50	1-90	1	100	2-98	1	0	0-100	.	.		13	15	1-39	4	0	0-91	.	.		9	11	0-52	5	0	0-98
MEMORIAL HOSPITAL OSTEO GREELEY CO 80631	1	0	0-97	1	100	1-97	.	.		.	.		1	0	0-100	1	0	0-100	.	.		.	.		.	.	
MERCY MEDICAL CENTER DENVER CO 80206	10	20	3-56	3	67	9-91	58	7	4-21	6	0	0-100	164	5	3-11	101	6	1-13	18	0	0-80	141	6	2-10	113	0	0-7
MERCY MEDICAL CENTER OF DU DURANGO CO 81301	9	11	3-58	1	100	0-97	26	8	2-27	2	0	0-100	65	8	2-15	38	0	1-20	12	0	0-99	72	4	2-14	48	0	0-15
MONTE VISTA COMMUNITY HOSP MONTE VISTA CO 81144	1	0	0-97	1	0	3-100	1	0	0-100	.	.		13	0	0-40	1	0	0-100	1	0	0-100	12	8	1-41	3	0	0-99
MONTROSE MEMORIAL HOSP MONTROSE CO 81401	7	14	8-71	6	17	10-76	21	5	2-31	3	0	0-100	76	5	2-15	29	0	0-27	14	0	0-99	37	8	1-19	36	0	0-27
MOUNT SAN RAFAEL HOSP TRINIDAD CO 81082	2	0	0-92	8	38	11-70	12	8	1-42	.	.		25	4	1-25	10	0	1-47	.	.		14	7	1-37	11	9	0-57
NORTH COLORADO MEDICAL CTR GREELEY CO 80631	21	19	11-53	15	40	18-65	50	10	4-22	21	0	0-72	247	5	3-10	90	6	2-14	23	0	0-87	219	7	3-9	224	1	0-5
PARKVIEW EPISCOPAL MED CTR PUEBLO CO 81003	10	40	5-59	8	25	12-72	37	8	3-24	20	0	0-86	131	4	2-11	45	0	1-19	18	0	0-98	120	3	2-10	86	0	0-9
PENROSE HOSPITAL COLORADO SPRINGS CO 80907	36	22	10-45	29	34	18-54	123	10	4-16	38	0	0-59	263	4	3-10	119	1	1-12	29	0	0-54	252	6	3-8	271	0	0-5
PIONEERS HOSP OF RIO BLANC MEEKER CO 81641	.	.		.	.		.	.		.	.		1	0	0-100	.	.		.	.		3	0	0-96	1	0	0-100
PIONEERS MEMORIAL HOSPITAL ROCKY FORD CO 81067	1	0	1-97		.		1	0	0-98	.	.		.	.		.	.		.	.		.	.		.	.	
PLATTE VALLEY MEDICAL CTR BRIGHTON CO 80601	5	20	3-72	6	33	9-75	15	0	1-37	.	.		39	3	1-18	4	0	0-92	1	0	0-100	38	5	1-18	19	0	0-37
PORTER MEMORIAL HOSPITAL DENVER CO 80210	28	25	9-47	16	38	19-66	36	22	3-25	191	0	0-4	231	6	3-10	79	3	1-14	4	0	0-100	320	6	3-8	149	2	0-6
POUDRE VALLEY MEMORIAL HOS FORT COLLINS CO 80521	21	19	9-50	10	60	16-72	65	6	4-19	8	0	0-98	152	10	3-12	82	2	1-13	21	5	0-66	147	4	2-10	247	3	1-5
PRESBYTERIAN DENVER HOSPIT DENVER CO 80218	22	23	10-51	18	56	16-60	95	6	5-19	74	1	0-13	225	8	3-10	119	2	1-12	23	9	0-37	297	4	3-8	263	2	1-5

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
PROWERS MEDICAL CTR LAMAR CO 81052	CO-61 *	209	18	10-22	12	50	9-58	10	20	10-62	7	0	3-60	10	40	9-62	9	67	15-72	6	0	2-64	32	16	9-38
RANGELY DISTRICT HOSP RANGELY CO 81648	CO-62 *	12	0	2-44	1	0	0-97	1	0	1-97	.	.		2	0	0-90	1	0	0-97	.	.		3	0	0-87
ROCKY MOUNTAIN HOSP DENVER CO 80220	CO-63	452	11	7-16	29	24	8-39	19	16	13-52	6	17	2-63	31	23	11-40	8	38	13-73	13	0	4-48	46	20	10-35
ROSE MEDICAL CENTER DENVER CO 80220	CO-64	2191	9	7-13	159	19	15-32	46	33	17-44	54	15	6-28	83	20	14-33	43	26	25-55	28	11	4-34	170	15	13-27
ROUTT MEMORIAL HOSPITAL, I STEAMBOAT SPRINGS CO 80487	CO-65 *	90	8	4-18	1	0	1-97	.	.		1	0	0-97	2	0	1-89	1	0	1-97	.	.		18	17	7-45
SALIDA HOSPITAL SALIDA CO 81201	CO-66 *	297	16	10-19	17	12	7-47	12	25	12-61	5	0	1-68	11	18	13-64	17	59	19-63	6	33	2-64	41	24	13-40
SEDGWICK COUNTY HOSP JULESBURG CO 80737	CO-67 *	85	19	7-23	8	63	7-64	3	33	3-83	3	0	0-82	3	33	2-82	2	0	6-94	2	0	0-91	7	29	8-69
SOUTHEAST COLORADO HOSPITA SPRINGFIELD CO 81073	CO-68 *	125	14	12-27	3	33	4-84	4	0	7-82	6	50	4-68	7	29	8-68	9	44	21-79	6	17	2-64	13	15	10-57
SOUTHWEST MEMORIAL HOSPITA CORTEZ CO 81321	CO-69 *	377	11	8-17	16	25	6-46	5	20	4-72	13	15	4-47	11	18	7-55	14	36	16-63	10	20	6-58	70	14	10-30
ST ANTHONY HOSPITAL SYS DENVER CO 80204	CO-70	3409	12	8-14	252	28	17-33	85	32	18-38	81	10	9-28	115	25	15-32	145	28	29-46	52	23	9-33	299	15	14-26
ST FRANCIS HOSP SYSTEMS COLORADO SPRINGS CO 80903	CO-71 *	1238	11	7-14	67	19	11-33	50	26	16-41	32	22	5-32	44	16	12-37	56	50	26-52	27	11	5-36	127	13	10-26
ST JOSEPH HOSP DENVER CO 80218	CO-72	3638	9	8-14	315	17	18-33	79	25	19-40	80	13	11-32	135	15	15-30	117	27	27-47	54	26	14-40	274	20	14-26
ST JOSEPH HOSP OF DEL NORT DEL NORTE CO 81132	CO-73 *	125	12	7-20	4	0	4-78	.	.		10	20	2-50	7	0	5-65	6	17	8-73	1	100	0-98	18	28	8-46
ST JOSEPH HOSPITAL FLORENCE CO 81226	CO-74	156	15	8-20	1	0	0-99	4	25	5-80	6	0	1-63	9	33	6-59	10	40	15-69	1	0	0-97	39	18	10-36
ST JOSEPH HOSPITAL OF THE CHEYENNE WELLS CO 80810	CO-75	47	21	8-30							2	0	0-90	5	20	4-71	6	33	11-76	1	100	0-98	5	0	2-69
ST LUKES HOSPITAL DENVER CO 80203	CO-76 *	2232	10	8-14	163	19	15-32	43	37	17-44	50	10	7-31	79	20	17-36	56	36	27-54	35	23	6-35	167	14	14-28
ST MARY CORWIN HOSP PUEBLO CO 81004	CO-77	2577	12	9-15	231	27	19-35	75	13	18-39	58	36	11-34	90	32	16-34	105	36	29-49	41	17	8-35	172	17	14-29
ST MARYS HOSP/MED CTR GRAND JUNCTION CO 81501	CO-78 *	1846	10	9-16	194	16	17-33	74	15	17-38	32	13	6-34	71	15	14-34	82	40	27-50	31	10	9-41	154	15	13-28
ST THOMAS MORE HOSPITAL CANON CITY CO 81212	CO-79	599	10	8-15	27	19	7-39	19	21	11-50	37	8	5-30	19	0	8-46	19	47	20-62	14	14	4-47	77	18	10-29
ST VINCENT GENERAL HOSP LEADVILLE CO 80461	CO-80 *	96	4	6-20	2	100	3-91	2	50	1-89	2	0	0-93	7	0	5-64	1	0	0-97	2	0	0-93	18	0	5-42
SWEDISH MEDICAL CENTER ENGLEWOOD CO 80110	CO-81	2168	10	7-14	125	18	15-33	78	28	18-39	40	18	6-31	54	31	12-35	74	45	27-50	36	22	7-35	238	18	13-26
UNION PRINTERS HOME AND HO COLORADO SPRINGS CO 80901	CO-82	7	29	8-68	.	.		2	50	2-90	1	100	1-97	.	.		.	.		.	.		4	0	4-78
UNIVERSITY HOSP DENVER CO 80262	CO-83	1268	11	7-13	101	24	18-39	27	19	13-46	19	26	5-41	30	17	9-39	41	39	24-54	22	14	3-37	83	27	9-26
US AIR FORCE ACADEMY HOSP COLORADO SPRINGS CO 80912	CO-84 *	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VAIL VALLEY MED CTR VAIL CO 81657	CO-85 *	40	3	4-25	.	.		.	.		1	0	0-100	3	0	2-81	4	0	3-76	2	0	1-89	7	14	4-62
VALLEY VIEW HOSP GLENWOOD SPRINGS CO 81601	CO-86 *	337	7	7-16	19	16	7-44	8	25	8-65	15	7	6-47	27	22	10-42	8	0	15-75	7	0	2-60	21	14	8-44

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
PROWERS MEDICAL CTR LAMAR CO 81052	5	20	4-73	8	25	12-72	9	11	1-50	.	.		21	10	1-28	10	10	1-47	4	0	0-95	12	17	0-42	7	0	0-81
RANGELY DISTRICT HOSP RANGELY CO 81648	.	.		.	.		.	.		.	.		.	.		1	0	0-100	.	.		.	.		2	0	0-100
ROCKY MOUNTAIN HOSP DENVER CO 80220	5	20	3-72	4	100	7-82	7	14	0-60	.	.		47	2	1-16	18	6	1-33	3	0	0-100	25	12	1-24	32	3	0-33
ROSE MEDICAL CENTER DENVER CO 80220	22	18	9-49	16	31	16-62	61	10	3-19	11	0	0-99	199	8	3-10	121	6	2-12	21	0	0-88	188	5	2-9	256	2	0-4
ROUTT MEMORIAL HOSPITAL, I STEAMBOAT SPRINGS CO 80487	3	0	1-82	2	0	1-89	8	0	0-55	.	.		8	13	0-63	3	0	0-94	1	0	0-100	3	0	0-93	11	0	0-79
SALIDA HOSPITAL SALIDA CO 81201	5	20	2-71	2	0	5-93	15	27	1-37	.	.		45	7	1-17	6	0	0-82	5	0	0-100	17	0	0-33	12	8	0-41
SEDGWICK COUNTY HOSP JULESBURG CO 80737	.	.		1	100	2-98	1	0	0-100	.	.		7	14	1-57	4	0	0-90	2	0	0-100	10	10	0-51	3	0	1-81
SOUTHEAST COLORADO HOSPITA SPRINGFIELD CO 81073	3	0	7-89	1	100	2-98	4	25	1-74	.	.		10	0	1-47	8	13	3-56	.	.		30	7	1-23	1	0	0-100
SOUTHWEST MEMORIAL HOSPITA CORTEZ CO 81321	4	25	2-76	3	33	4-84	15	0	1-37	.	.		47	9	3-20	2	0	0-99	4	0	0-100	32	3	2-22	19	0	0-48
ST ANTHONY HOSPITAL SYS DENVER CO 80204	27	30	9-47	27	44	21-58	98	12	3-16	4	0	0-100	336	7	3-9	147	6	1-11	31	0	0-35	382	6	3-8	226	2	0-5
ST FRANCIS HOSP SYSTEMS COLORADO SPRINGS CO 80903	11	27	10-64	14	36	15-63	57	7	3-19	6	0	0-98	100	4	1-11	56	7	1-16	18	0	0-92	61	7	1-13	133	2	0-6
ST JOSEPH HOSP DENVER CO 80218	21	19	9-51	28	29	22-59	80	9	4-18	54	0	0-28	317	4	3-9	186	4	1-10	40	0	0-55	327	6	3-8	357	1	1-4
ST JOSEPH HOSP OF DEL NORT DEL NORTE CO 81132	3	0	1-82	.	.		3	0	0-91	.	.		17	6	1-32	2	0	0-93	.	.		6	17	0-67	3	0	0-100
ST JOSEPH HOSPITAL FLORENCE CO 81226	1	0	0-98	.	.		1	0	0-99	.	.		13	15	0-40	7	0	0-65	5	0	0-100	18	6	0-31	7	0	0-85
ST JOSEPH HOSPITAL OF THE CHEYENNE WELLS CO 80810	2	0	2-90	1	0	1-97	3	33	0-83	.	.		4	25	0-80	1	0	0-100	1	0	0-100	3	0	0-91	2	0	0-100
ST LUKES HOSPITAL DENVER CO 80203	29	17	6-43	15	47	14-61	39	23	3-23	10	0	0-91	123	8	3-13	87	2	2-14	15	0	0-76	359	3	3-8	132	2	0-7
ST MARY CORWIN HOSP PUEBLO CO 81004	30	23	8-45	42	36	23-54	99	7	4-17	7	0	0-100	248	8	3-10	151	1	1-11	36	0	0-57	191	5	2-9	256	3	0-4
ST MARYS HOSP/MED CTR GRAND JUNCTION CO 81501	10	30	6-61	23	26	19-59	50	4	2-20	10	0	0-99	162	6	2-9	93	1	1-13	26	0	0-77	144	3	2-10	174	0	0-5
ST THOMAS MORE HOSPITAL CANON CITY CO 81212	3	33	5-87	11	18	12-65	25	12	2-27	12	0	0-99	49	6	2-17	30	0	0-24	12	0	0-99	56	7	1-15	28	7	0-28
ST VINCENT GENERAL HOSP LEADVILLE CO 80461	3	0	2-82	2	0	2-90	.	.		1	0	0-100	13	0	0-42	1	0	0-99	1	0	0-100	4	0	0-86	4	0	0-99
SWEDISH MEDICAL CENTER ENGLEWOOD CO 80110	11	9	3-54	9	33	14-72	90	7	3-16	1	0	0-100	237	2	3-9	116	0	1-12	61	0	0-24	83	6	2-13	290	1	0-4
UNION PRINTERS HOME AND HO COLORADO SPRINGS CO 80901	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
UNIVERSITY HOSP DENVER CO 80262	59	8	2-34	7	71	14-78	21	5	1-30	7	0	0-100	82	7	2-14	29	0	0-24	15	0	0-92	94	14	2-12	63	0	0-13
US AIR FORCE ACADEMY HOSP COLORADO SPRINGS CO 80912	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VAIL VALLEY MED CTR VAIL CO 81657	.	.		.	.		1	0	0-100	.	.		1	0	0-100	.	.		1	0	0-100	4	0	0-83	5	0	0-100
VALLEY VIEW HOSP GLENWOOD SPRINGS CO 81601	4	50	2-76	4	25	7-83	11	9	1-45	.	.		36	0	1-20	16	0	0-41	5	0	0-100	26	4	1-23	48	0	0-15

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WALSH DISTRICT HOSP & NH WALSH CO 81090	CO-87 *	36	14	4-27	1	100	3-99	.	.		1	0	0-99	2	0	0-90	2	100	5-93	2	0	0-90	3	33	1-81
WASHINGTON COUNTY PUBLIC H AKRON CO 80720	CO-88 *	57	19	6-26	.	.		5	40	4-72	2	50	0-91	3	67	5-85	2	50	4-92	3	0	0-84	15	27	6-46
WEISBROD MEMORIAL COUNTY H EADS CO 81036	CO-89 *	8	13	2-55	.	.		.	.		.	.		.	.		2	50	3-91	1	0	0-98	1	0	0-97
WRAY COMMUNITY DIST HOSP WRAY CO 80758	CO-90 *	130	14	7-20	3	67	1-81	6	50	7-71	5	17	1-63	11	18	7-56	7	43	11-73	3	33	1-81	18	22	6-42
YUMA DISTRICT HOSP YUMA CO 80759	CO-91	93	18	8-24	2	100	3-91	7	29	10-72	2	0	1-89	8	13	6-61	7	43	10-72	.	.		14	14	4-45

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
Name/ Location	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WALSH DISTRICT HOSP & NH WALSH CO 81090	.	.		1	0	0-97	1	0	0-100	.	.		3	0	0-95	4	0	0-76	.	.		4	0	0-77	1	0	0-100
WASHINGTON COUNTY PUBLIC H AKRON CO 80720	1	0	0-99	.	.		.	.			.		8	0	0-54	1	0	0-100	.	.		3	33	0-97	4	0	0-93
WEISBROD MEMORIAL COUNTY H EADS CO 81036	.			.	.		.	.		.	.		1	0	0-100	.			.			1	0	0-100	.		
WRAY COMMUNITY DIST HOSP WRAY CO 80758	.	.		1	0	1-97	1	0	0-100	.	.		22	0	1-27	6	0	0-83	.			10	20	0-48	4	0	0-100
YUMA DISTRICT HOSP YUMA CO 80759	.	.		1	0	1-97	1	0	0-100	.	.		8	0	0-56	4	25	0-77		.		9	0	0-51	3	0	0-99

*Written Comments Not Submitted.

AMC
Cancer Research
Center

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and
Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Medicare Provider #06-0099

Dear Dr. Roper:

I write in response to your letter of September 21, 1987 regarding HCFA's plans to publish selected mortality information for 1986.

The comments which we would like you to include in the December publication are attached, and we believe our comments economically convey the methodological fallacy involved in the study as it applies to AMC Cancer Research Center, a specialty institution which in its clinical activities combines skilled nursing care and acute hospital care for cancer. Medicare regulations require a three day acute care stay before admission to a Skilled Nursing Facility is permitted. To have HCFA prepare mortality statistics which gloss over this Medicare requirement results, at least in the case of AMC and perhaps other like institutions, in a distortion of the mortality rate.

We suggested to your office in a telephone conversation with Mr. Harvey Brooks that only the acute mortality rate of patients who were not ultimately admitted to our Skilled Nursing Facility be reported. This request was denied. We certainly can understand devotion to methodology, and an unwillingness to depart from it. Nevertheless, at least in the case of AMC, your methodology may well mislead. We suggest, at least in any introductory material submitted with your report, that the public be advised to use these statistics with care. More specifically, we suggest that HCFA point out that your mortality statistics must be reviewed in light of the varied types of institutions to which they are to be applied.

1600 Pierce Street
Denver, Colorado 80214
303 233-6501

We urge you to consider carefully your approach and to pay particular care as to how these statistics are introduced both in your report itself and to the press. Doing harm for a good purpose is still harm, no matter the purity of the intent.

Sincerely,

Gary A. Knight
Senior Vice President
Finance and Administration

GAK/jmc
Attachment

AMC
Cancer Research
Center

Medicare Provider #: 06-0099

The mortality statistics concerning AMC Cancer Research Center must be interpreted in light of the fact that AMC provides, among other things, skilled nursing care to patients with advanced cancer, many of whom will be terminal.

AMC Cancer Research Center is a cancer care and research facility with 32 beds of which 12 beds are licensed for acute hospital care and 20 beds are licensed as a skilled nursing facility (SNF) that is utilized for long term rehabilitation or terminal care. All AMC patients have cancer. All Medicare patients to be admitted to the SNF first have a three-day qualifying stay in the acute care hospital before transfer to the SNF.

All but two of the 13 deaths used for the calculation of mortality rates in AMC's acute care hospital relate to patients who were admitted to AMC's acute care facility specifically as a precursor to terminal care in AMC's SNF. By contrast, in 1986 there were 27 acute hospital admissions that were not expressly for later placement in SNF and among these patients the average length of stay was 5.2 days and the mortality rate was 7.5%.

1600 Pierce Street
Denver, Colorado 80214
303 233-6501



October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Hospital Medicare Mortality Information

Gentlemen:

This will acknowledge receipt of our hospital specific Medicare mortality information.

These statistics have been reviewed and validated as correct in accordance with your established criteria.

Sincerely,

Marjorie Rohde

Marjorie Rohde, ART
Director Medical Records and
QA Coordinator

/mr

copy: Hans Wiik, CEO
T. Trask, R.N.
S. Barlow-Perez, Marketing

Boulder
Community
Hospital

PO Box 9019
N. Broadway & Balsam
Boulder, Colorado
80301-9019
(303) 440-CARE

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: Mortality Data from Boulder Community Hospital

Boulder Community Hospital is the leading acute care hospital and health care center in the Boulder area. As a caring institution and a private, not-for-profit business, 172-bed Boulder Community Hospital provides excellence in health care and:

- Recognizes and supports the physical, emotional and spiritual needs of patients and families;
- Provides a comprehensive range of services, programs and facilities which are appropriate to its role, responding to community needs consistent with overall economic justification;
- Provides emergency services to all, regardless of ability to pay; and provides a reasonable amount of non-emergency service to those who cannot pay full cost;
- Strives for the highest level of technical and professional competence within the constraints of resources available;
- Provides health education programs for patients, physicians, employees and the public;
- Provides an environment which promotes growth and opportunity for its human resources.

Quality assurance at Boulder Community Hospital is:

- Integrated with risk management process and the physician quality assurance process;
- Department-based, monitoring quality and appropriateness of care.

All interdepartmental quality assurance concerns are addressed by the hospital's administrative staff.

Response to mortality data from Boulder Community Hospital:

1. One correction - Patient [redacted], diagnostic category CA is still alive. This was miscoded.

VHA
Partner-VHA/
Mtn States
Affiliate of the
Voluntary Hospitals
of America System

2. Twenty-three out of 110 died 30 days past discharge. Eight died at home and 15 died in skilled nursing facilities or other health care facilities. It demonstrates accurate placement for patients who no longer need acute care services and appropriate discharge planning.
3. The reasoning behind the higher than predicted range for CE (53%) is the fact that we are the only emergency facility in our service area. All were admitted through the ER and presented with acute symptoms. The average age of this group was high as well.

Sincerely,

Sandra E. Steele

SANDRA E. STEELE
Executive Vice President
Acting President/CEO

SES:sn

MEDICARE PROVIDER #060027

MEMORIAL HOSPITAL
BOULDER

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Medicare Provider Number: 06-0051

In regards to the planned December, 1987 publication of selected mortality information, we have completed our review and are submitting the following comments:

1. The data used by HCFA indicates that a total of 463 Medicare patients were admitted to Boulder Memorial Hospital in 1986, while our own records indicate that 542 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Therefore, we have no means of verifying your stated numbers.

2. The data also reflects that the number of patients who died within 30 days of admission were 27, of which 14 died within 30 days of admission, while still an inpatient. As indicated on the enclosure, 2 of the cases were <u>not</u> admitted to this hospital.

3. It is impossible to determine the percentage of the 13 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Member, Adventist Health System
311 Mapleton Avenue Boulder, Colorado 80302-4798 (303) 443-0230

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

4. Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Thank you for your consideration regarding these comments.

Sincerely,

Warren M. Clark
President

WMC/rs

Enclosure

Delta County
Memorial
Hospital

Oct. 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Sirs:

Please find our response to the 1987 HCFA Mortality Data attached to this letter. Thank you for allowing providers to present their comments along with the data.

Sincerely,

Daniel Reust
Business Office Manager

cc: Ken Moore, DCMH
Linda Mesaric, DCMH
Marie Keenan, DCMH

100 Stafford Lane Delta, Colorado 81416-2297 (303) 874-7681

COMMENTS ON THE HCFA MORTALITY DATA

For the past two years, the Health Care Financing Administration (HCFA), a branch of the federal government, has published mortality rates on a hospital by hospital basis. In prior years, hospitals were given no chance to comment on or interpert the data.

The attached data from HCFA is the result of a statistically complicated, and questionable method of looking at the data the government collects.

It is important to realize that these statistics are not good measures of hospital performance or quality of care. HCFA itself says "...we cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals." This comment is taken from a letter from William L. Roper, M.D., the Administrator of HCFA, on September 21, 1987.

Specifically, one major concern is the definition of the data items used in the statistics. The column "Actual Mortality Rate" is a summary of patients who expired in the hospital, or within 30 days after a hospital stay. This definition is only one of the many possible mortality statistics, but because HCFA chooses to use a definition that includes data to which hospitals do not have access (in the case deaths after, not necessarily during, a hospital stay), it is nearly impossible for an individual hospital to verify the data's accuracy. Similar definitional concerns occur on other data items.

Secondly, the "Range of Predicted Mortality Rates" is a mathematically derived range of the percent of expected cases that end in death which are statistically reasonable for various types of illnesses or surgeries. We were not given the specifics of how this range is calculated. Comparing individual hospital statistics to these ranges presents several problems. As a small hospital, there tends to be a small number of patients in some categories. Figures of this nature gain significance, in the statistical sense, only if there is a large number of patients. Example: One death out of two patients is not as statistically significant as 50 deaths out of 100 patients. The other problem is that the "Range of Predicted Mortality Rates" is not meaningful. As an example, several have the range of 0% to 100%.

Again, even with these specific concerns, it is more important that we disagree with the entire methodology of the information HCFA released.

It has little, if any, indication of hospital performance or quality of care.

This hospital prefers to rely on an intensive and exhaustive quality review process, utilizing physician, nursing and associated professionals to identify potential quality of care problems and correct them long before HCFA personnel have calculated and issued their statistics.

Denver General Hospital's Comments on HCFA File Code HSQ-148-GNC
(Medicare Program: Selected Performance Information on Hospitals)
Providing Care to Medicare Beneficiaries

Denver General Hospital has examined the mortality data which HCFA will publish in December, 1987, and finds its actual mortality rates to be within the 95% confidence intervals of expected mortality rates for all diagnostic categories and below the mid-point of the ranges for all but 4 of the 17 diagnostic categories. For one of these categories, metabolic electrolyte disturbances, Denver General's actual mortality rate (26%) was very close to the mid-point of the expected range (22%). For the other three diagnostic categories, Denver General's actual rates were toward the higher end of the ranges as indicated in Table 1, below, even though they were within these ranges:

Table 1

Diagnostic Category	DGH Actual Mortality Rate	Predicted Range
Cerebrovascular Accidents	44%	16-48%
Severe Acute Heart Disease	54%	22-61%
Pulmonary Disease	23%	8-27%

Consequently, a review was conducted of the 39 individual cases represented in Table 1. Aspects of these cases which relate to their severity, a characteristic not taken into account by HCFA's methodology, are noted below in the belief that they are important to a correct understanding and interpretation of these data.

The published statistics include eight deaths involving cerebrovascular accidents. All eight patients were admitted directly to an Intensive Care Unit through the Emergency Room after being initially treated and transported to the hospital by paramedics (seven of the eight were found down in the field). Six of the eight were intubated and required mechanical ventilation. Seven were designated "no Cor" after the initial event based on their wishes or those of their family, due to poor prognosis.

Thirteen deaths involved severe acute heart disease. All thirteen patients were admitted through the Emergency Room, with eleven of these going directly to Intensive Care Units. Ten had been treated and transported by paramedics. Eight were found down in the field. Twelve required intubation and mechanical ventilation. Ten were designated "no Cor" after the initial event and the other three were not successfully resuscitated.

Eighteen deaths involved a principal diagnosis of pulmonary disease. Of these, sixteen were admitted through the ER, with fourteen being transferred directly to an intensive care unit. Eleven of these patients required intubation and mechanical ventilation. Twelve of these deaths were due to sepsis, two had respiratory arrests in the Emergency Room, one had terminal lung cancer, and one had endstage chronic obstructive pulmonary disease.

In summary, 95% of the cases represented in Table 1 were emergency admissions to the hospital, over half of these having been treated and transported by Denver General's Paramedic teams. Thus most of these patients arrived at Denver General due to the hospital's role as operator of the 911 system. The severity and the emergent nature of these patients explains the fact that their mortality rates, while within HCFA's predicted ranges, were toward the upper end of the 95% confidence intervals.

9191 Grant Street
Thornton, Colorado
80229
Telephone 303 451-7801

Humana Hospital
Mountain View

October 23, 1987

Dr. William L. Roper, M.D.
Administrator Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P.O. Box 26676
Baltimore, MD 21201

Dear Dr. Roper:

We appreciate the opportunity to comment on the hospital specific mortality data provided to us by the Department of Health and Human Services. Humana Hospital - Mountain View supports efforts to preserve and improve the quality of care provided to not only Medicare patients but also the population as a whole.

As a routine matter, Humana Hospital - Mountain View has several internal programs in place for the purpose of ensuring that high quality medical care is given to the patients who choose this facility for hospital services. Such efforts include an ongoing quality assurance program that is comprised of regular and complete mortality/morbidity review, generic quality screens that are specific for each medical specialty, and a utilization review process that encourages appropriate use of medical services. All programs involve active participation by members of the medical staff as well as specially trained hospital personnel. In addition, we voluntarily participate in the accreditation process conducted by the Joint Commission on Accreditation of Health Organizations (JCAHO) and openly cooperate with the Professional Review Organization (PRO) for the State of Colorado.

While we see no cause for concern with regard to the mortality rates reported for this hospital, it is important that several factors be considered when examining the data for any hospital. They are:

1) The number of deaths reported deal only with a limited segment of the population (the elderly) which are generally considered to be at higher risk.

2) There is no adjustment for severity of illness or complicating factors that may affect patient outcome.

3) In some instances, the number of cases in a particular category is too small to provide a valid statistical analysis.

4) The predicated ranges are very broad and have been developed in such a complex and unverifiable manner that it is impossible to make a judgment as to whether they are acceptable or unacceptable "standards."

5) Since a number of the reported deaths occurred outside of the hospital, some of the data cannot be validated.

As in all deaths that occur in hospitals, a complete internal review is necessary to determine if appropriate care was rendered. Our hospital's medical records department, quality assurance committee, and medical staff review all such cases and may provide information to physicians and other health providers that will ultimately lead to improvements when treating future patients.

We recognize this program is in its early developmental stages and hope this information can be refined in the future. If so, accurate, meaningful data can be provided to hospitals as they seek to improve the quality of care and to patients as they make choices about where to obtain hospital services. Our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Jack Shapiro
Executive Director

Roger R. Marquardt, D.O.
Chief of Staff

lm

Humana Hospital
Aurora

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

I'd like to thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-Aurora supports the Health Care Financing Administration's desire to educate those specifically interested in Medicare quality issues. We acknowledge that this program is in its infancy. While its measurements are preliminary I do believe it's only the first step of the type of quality measurements to come.

This information is beneficial in our hospital's ongoing quality assurance program that includes regular and comprehensive review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. Consumers should be informed as to the limited scope of these numbers, and be strongly cautioned about drawing any conclusions from the data about the quality of any particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place

in hospitals.

Our hospital's (medical records, quality assurance, and/or medical staff) has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent [with some (major) exceptions] with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Respectfully,

William K. Atkinson
Executive Director

kfm

Lincoln Community Hospital and Nursing Home

P.O. Box 248
111 6th St.
Hugo, Colorado 80821

Phone (303) 743-2421

October 8, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: 1986 Reported Mortality Death Rates for Lincoln Community Hospital, Hugo Colorado 06006.

In reviewing the "actual mortality rates" for Lincoln Community Hospital the following was found:

1. 50% mortality rate for gastrointestinal catastrophes is misleading. One of the two patient deaths in this category occurred eigth (8) days after discharge to a nursing home. Death was not due to gastrointestinal catastrophes, but was related to the patient's advanced age of 96 years. The other patient had an underlying condition of generalized carcinoma with metastisis to vital organs. Given the patient's age of 77 years and underlying condition, the expected outcome for this patient was death.

2. 33% mortality rate for severe chronic heart disease is misleading in that the one patient that died was 84 years of age and had a long history of heart disease.

3. 57% mortality rate for severe acute heart disease is misleading. Two of the four patients had underlying conditions of chronic heart failure and were of advanced age. One of the patient's died of a massive rupturing of an aorta at age 75. The other patient died shortly after being brought to the hospital of a heart attack at age 72.

4. 50% mortality rate for renal disease is misleading. The one patient that died had chronic renal failure secondary to diabetes. The patient had elected to have no further treatment and had been receiving supportive care at home 10 days prior to death. This patient died at home and not in the hospital at age 91.

Given the advanced age of the patients who died, their general health at the time of their death, the fact that two of the patients were not in the hospital at the time of death, and the small sample size, we find the mortality rates to be very misleading.

Sincerely,

Delores Nance
Chief Executive Officer

Logan County Hospital

615 Fairhurst
P.O. Box 3500
Sterling, Colorado 80751—0500
(303) 522-0122

October 14, 1987

DEPARTMENT OF HEALTH AND HUMAN SERVICES

RE: Review of 1986 deaths.

TO WHOM IT MAY CONCERN:

In answer to your request regarding the mortality rate review upon the DRG category of pulmonary disease, the two charts which I was asked to comment on, inclusive of [redacted], who are deceased [redacted], had multiple similarities, inclusive of:

1. Significant long-term chronic obstructive pulmonary disease, both with recent exacerbations prior to their demise.
2. Both had arteriosclerotic heart disease and congestive heart failure.

Both of these patients were on a multitude of medications which they further refused administration of. Ironically, [redacted] was opposed to medications, although [redacted] was having her medicines provided via Medicaid. Both patients did receive close surveilance via family members and Home Health Services, although, and more importantly, both patients and families requested that the patients be NO COR status. Thus, in review of the patient's charts, all appropriate care in anticipation of these patient's progressive demise was rendered in such a manner that the patient as well as the family desired in terms of the standards of medical care during 1986.

In conclusion, no alternative treatment appears to be additionally necessitated in [redacted] circumstances.

A financial renumeration for the time and services which I have provided to your department for these summaries will be forthcoming.

Sincerely,

Robert J. Fillion, D.O.

RHF/vm

8300 West 38th Avenue
Wheat Ridge, Colorado 80033
(303) 425-4500

CONFIDENTIAL

LUTHERAN
MEDICAL CENTER

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper,

Attached are comments from Lutheran Medical Center (Provider number 060009). Please note that we have corrected the medical record coding on one case which results in a change in our death rates for the Major Trauma and Cancer categories. We would appreciate this change being made in the published rates.

Please do not hesitate to contact me or Andrea Mitchell with any questions you might have about this correction or the comments on the attached pages.

Sincerely,

Frank Traylor, M.D.
Vice President of Medical Affairs

cc: Richard L. Taylor
John Woodward, M.D.
Andrea Mitchell

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

COMMENTS ON THE HCFA MORTALITY DATA
LUTHERAN MEDICAL CENTER, WHEAT RIDGE, COLORADO

Data Verification

The data used by HCFA indicate that, of a total of 3169 cases admitted to Lutheran Medical Center in 1986, 323 patients (or 10.2%) died within 30 days of admission. Of these, 231 (or 71.5%) died while still patients in the hospital while 92 (28.5%) died after discharge.

Our own records indicate that 4623 Medicare discharges occurred in 1986. Our records show that of these 4623 cases, there were 238 deaths or a death rate of 5.15%. Without additional information, we cannot verify the HCFA data regarding number of cases or deaths which may have occurred following discharge.

There is one category in which Lutheran's deaths exceed the expected range. The medical records of these cases were reviewed by Dr. Frank Traylor, Vice President of Medical Affairs. In one instance it is clear that the case was misclassified due to a diagnosis coding error. We are pursuing the correction of this problem which would result in the patient's death being classified in the Cancer group (thus raising the number of cancer deaths to 36) rather than the Major Trauma group (lowering the number of deaths in that category to 12 or 19%). Information from the patient's record is attached which verifies that the hospitalization and subsequent death were, in fact, due to cancer rather than trauma. We are in the process of officially correcting the record to indicate a principal diagnosis of hepatocellular carcinoma.

Of the twelve remaining deaths in the Severe Trauma category, there are at least five which are worthy of discussion. The data are designed to reflect on the care delivered by a hospital or physician provider. In three cases the patients suffered fractured hips (two in the nursing home) and were transferred to the hospital. In all three cases the families requested that there be no surgical intervention. The patients were discharged; two to nursing home and one to hospice where they subsequently died. The fourth case was admitted from the nursing home in extremis and died without treatment. The fifth case was a patient who had known lymphoma who was admitted to the hospital with subdural hematoma for whom the family requested no heroic measures. The patient died within hours of hospital admission. It is our position that these cases do not reflect on the treatment provided by the hospital.

Interpretive Remarks

Lutheran Medical Center notes that our overall death rate is at the low end of the expected range. We appreciate that the Health Care Financing Administration recognizes the limitations of these data. We recognize that death rate statistics do not describe fully a hospital's level of quality. We also recognize the limitations of the study methodology which focuses on only a few variables associated with predicted mortality.

With the correction in diagnosis coding for one death in the major trauma category, the death rates for all of the categories are within the expected range.

Quality Assurance Activities as a Result of Review

As part of our quality assurance process, all deaths which occur in the hospital are reviewed by quality assurance physicians to identify any potential areas for education and/or corrective action. The quality assurance process is designed to monitor and identify cases for review so that we can be assured that we are maintaining a high level of quality for Medicare and non-Medicare patients alike.

The results of this scrutiny are reflected in our death rate which, at 10.2%, is low within the predicted range based on the HCFA methodology.

HOSPITAL = 060009 LUTHERAN HOSP AND MED CTR WHEAT RIDGE CO

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	3,169	10 %	8 TO 14 %
CA - CANCER	~~236~~ 237	15 %	15 TO 30 %
CE - CEREBROVASCULAR ACCIDENTS	70	29 %	19 TO 41 %
EY - OPHTHALMOLOGIC DISEASE	19	0 %	0 TO 76 %
GC - GASTROINTESTINAL CATASTROPHES	84	11 %	9 TO 29 %
GI - GASTROINTESTINAL DISEASE	325	6 %	3 TO 8 %
GU - UROLOGIC DISEASE	130	3 %	2 TO 12 %
GY - GYNECOLOGIC DISEASE	51	0 %	0 TO 24 %
HL - LOW-RISK HEART DISEASE	182	7 %	3 TO 10 %
HM - SEVERE CHRONIC HEART DISEASE	122	30 %	16 TO 31 %
HS - SEVERE ACUTE HEART DISEASE	105	32 %	28 TO 48 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	68	16 %	9 TO 31 %
OP - ORTHOPEDIC DISORDERS	265	2 %	0 TO 4 %
PN - PULMONARY DISEASE	279	16 %	14 TO 26 %
RN - RENAL DISEASE	21	19 %	9 TO 50 %
SE - SEPSIS	25	40 %	20 TO 59 %
TR - SEVERE TRAUMA	~~63~~ 62	~~21~~ 19 %	4 TO 20 %

CO 41.3

CONFIDENTIAL

MELISSA MEMORIAL HOSPITAL
East Phillips County Hospital District
505 SOUTH BAXTER
HOLYOKE, COLORADO 80734
BOARD OF DIRECTORS
W. C. MC ELHANNON, ADMINISTRATOR
MC Provider # 060038

HEALTH CARE FINANCING ADMINISTRATION
HEALTH STANDARDS AND QUALITY BUREAU
HOSPITAL MORTALITY INFORMATION
PO BOX 26684
BALTIMORE, MARYLAND 21027

Dear Sirs:

The Mortality data as provided for patients admitted to Melissa Memorial Hospital during 1986, after careful review by our Medical Records Department, appears to be correct.

It should be noted that Melissa is a very small institution, thus making the # of cases in each diagnostic category to be very few, making the actual mortality rate appear high. This year, all of our actual mortality rates did fall within the range of predicted rates but had we have had only one case in a diagnostic category and that case died, our actual mortality rate in that diagnostic category would have been 100% which would appear very high to one who did not understand this data.

The patients who did expire from our facility were very elderly with the median age being 82 and the mean 84, the eldest being 94 and the youngest 76.

All deaths in our institution are reviewed by the Medical Staff Medical Care Appraisal Committee. If we are aware of deaths which occur within 30 days of discharge, we will in the future, review these also.

Thankyou.

SINCERELY,

W. C. McElhannon

W. C. McElhannon, Administrator
Melissa Memorial Hospital

WC/bmc

The MEMORIAL HOSPITAL

785 Russell Street ❖ Craig, Colorado 81625 ❖ 303-824-9411

October 26, 1987

Department of Health and Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Friends:

The Memorial Hospital has reviewed the ten cases which you have listed as deaths ocurring within 30 days of dishcarge from this hospital. In 9 of the 10 cases the patient did expire while an inpatient, and in the 10th case, the patient evidently expired outside the care of The Memorial Hospital.

The review of the 10 cases revealed that there was not a pattern of deaths attributed to any one doctor. Seven of the 10 cases were "do not resusitate" patients and (since we have no Hospice program) they were provided necessary supportive care here at the hospital until they expired.

At The Memorial Hospital, all deaths are reviewed as part of our ongoing peer review activity. In all of these cases, the peer review physicians found that the attending and consulting physicians acted appropriately in providing care.

In the one case where The Memorial Hospital fell outside of the H.C.F.A. expected mortality, the statistical model does not present a fair picture. Since we only had one Medicare patient with Sepsis during 1986 and since that patient had a perforated bowell on admission and subsequently expired, we are credited with a 100% mortality in that diagnostic category. We submit that the 100% death rate does not accurately represent the quality of care for this diagnostic category since we had only one opportunity in all of 1986 in the category.

Respectfully yours

M. Randell Phelps

M. Randell Phelps
Administrator

MRP/bjd



Porter Memorial Hospital

October 27, 1987

RESPONSE TO HCFA MORTALITY DATA
MEDICARE PROVIDER # 060064

I. Identify errors:

The HCFA Mortality List does match with the Porter Medicare Mortality List. The dates of discharge and/or death are correct. The principal diagnosis codes are correct. We have found no errors.

II. Interpreting data:

While Porter Memorial Hospital falls within the predicted range of mortality rates we strongly recommend that a discussion regarding hospital mortality statistics would include supplemental information in order to more appropriately interpret the data. Specifically an explanation regarding a hospital's adjusted case mix index and how that is calculated would be helpful in giving the consumer a clearer picture of a particular hospital's mortality statistics and how that compares with other hospitals. A hospital such as Porter Memorial Hospital with an adjusted case mix index of 1.24 would understandably be providing services to a patient sector with a higher than average risk of death at the time of admission or discharge given the patient's medical condition. Again, we would reiterate that this data in itself is not a measure of hospital performance.

The mortality report is based on the principal diagnosis which is defined as the reason why the patient was admitted. This reason for admission is often not the cause of death. Complications or other comorbid conditions that exist enter into the outcome of patient care.

2525 South Downing Street ● Denver, Colorado 80210 ● (303) 778-1955

Expected outcome after admission of a patient also is a factor that should enter into the analysis of the mortality report but is not reflected in the HCFA report. In looking at only three diagnostic categories (sepsis, severe trauma, pulmonary), 82% or fifty-four patients had "Do Not Resuscitate" orders on the medical record. This may reflect the value society places on the "quality" of life versus the "length" of life.

An analysis of the following DRG categories based on medical record review substantiate the above comments on case mix.

Sepsis:

A 38% mortality rate was reported on six patient deaths.

- -Mean age of 82 years
- -Secondary diagnosis/complications included two cancers, two pneumonias; one gastric hemorrhage, one possible gastrointestinal tract infection
- -Five of six patients had "Do Not Resuscitate" orders reflecting the expected patient outcome
- -Cause of death was Sepsis in all but one case

Severe Trauma:

A 22% actual mortality rate or eight patient deaths was reported. Six patients had a principal diagnosis of fractured hip, two patients had a principal diagnosis of cerebrovascular accident.

- -Mean age of 84 years for eight patients

Cerebrovascular accident patients:

- -Secondary diagnosis/complications included: pneumonia, post operative cataract with a fall, pneumonia with chronic atrial fibrillation and aortic stenosis;
- -Cause of death: respiratory arrest, brain stem hemorrhage
- -Both patients had "Do Not Resuscitate" order reflecting the expected patient outcome.
- -Both patients admitted from home.

Hip patients:

- -Secondary diagnosis/complications: pneumonia which was secondary to persistent encephalopathy and recurrent seizures; diabetes; atrial fibrillation; coronary artery disease; chronic obstructive pulmonary disease; post operative coronary artery bypass graft; emphysema.
- -Cause of death: Cardiac respiratory arrest for five patients; cerebrovascular accident for one patient.
- -Five of the six patients had "Do Not Resuscitate" orders reflecting the expected patient outcome.
- -Five patients were admitted from home, one from a nursing home.

Pulmonary:

A 22% actual mortality rate or fifty-four patient deaths was reported. Fifty-two medical records were reviewed.

Twenty-eight patients, or 55%, had a principal diagnosis of pneumonia.

-Mean age 76.1 years for all patients
-Secondary diagnosis/complications: cerebrovascular diseases; chronic respiratory disease; cancer; organic brain syndrome; diabetes; hepatic failure secondary to Tylenol overdose; anemia; cardiac and respiratory failure; duodenal ulcer.
-Forty-four, or 85%, of the patients had "Do Not Resuscitate" orders reflecting the expected patient outcome.
-Cause of death: twenty-seven cardiac/respiratory arrests; end-stage Parkinson's disease with pneumonia; two chronic heart failures; renal failure; cancer of the pancreas; hemorrhage/hemothorax, myocardial infarction; seven pneumonias; acute brain stem hemorrhage, cerebrovascular accident, four sepsis; cardiogenic shock, interstitial lung disease, bilateral pulmonary fibrosis.
-Thirty-five were admitted from home; fourteen were admitted from a nursing home; three were admitted from other facilities.
-Twenty patients expired after discharge from the hospital.

Deaths after discharge:

Twenty-four percent of the total number of reported deaths were within thirty days of discharge. According to medical record review, forty-eight of these patients were terminal, or in extremely poor condition and thus death was imminent. In fact twenty-two patients did expire in a hospice setting. Analysis of the other twenty-seven patients via physician telephone contact shows sixteen patients died in a nursing home, seven died at home and two died in a hospital. Two patients' records could not be traced.

As mandated by Medicare criteria, terminally ill patients, no longer requiring acute care therapies, can more appropriately be cared for in a less intense setting, i.e., hospice, skilled nursing facility or in the home setting. Therefore, this would explain that a certain number of discharged patients will indeed expire soon after discharge.

In summary, while we understand the intent of the data, i.e., "to present actual death rates for each hospital compared to what would have been expected for that particular hospital given the characteristics of patients admitted," it is important to reiterate that the HCFA data is not, and should not be, used as a measure of hospital performance or judgment of quality of care.

Yours truly,

John R. Hicks
Assistant Vice President
Patient Review/Risk Management
Porter Memorial Hospital

JRH/ab

POUDRE VALLEY HOSPITAL
1024 Lemay Avenue
Fort Collins, Colorado 80524
Phone (303) 482-4111

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

REF: Poudre Valley Hospital
Medicare Provider #060010

Dear Dr. Roper:

Thank you for this opportunity to comment on and correct the 1986 mortality information for Poudre Valley Hospital which HCFA plans to publish later this year. Although the issue of reporting hospital mortality data is complex and controversial, I shall confine our response to just a few short comments.

First, please be aware that the data for Poudre Valley Hospital that HCFA intends to release are incorrect as presented: HCFA's list of Medicare- patient deaths at Poudre Valley Hospital does not include the 11 names shown on the enclosed attachment. Furthermore, HCFA's list includes a number of Medicare patients who did not die at Poudre Valley Hospital. We have no information about the circumstances surrounding these deaths, which might have been caused by vehicle accidents, household accidents, illnesses unrelated to recent hospitalization, terminal illnesses for which no treatment was possible, or a host of other reasons.

The mortality data for Poudre Valley Hospital which HCFA intends to publish are "favorable," in that our actual mortality is within the predicted ranges. Still, we are extremely uncertain of the significance of this information and its appropriate use, particularly as a way for consumers to compare the quality of care delivered at individual hospitals.

Poudre Valley Hospital has for many years been active in attempts to define quality of care in meaningful ways. Our own quality-assurance program predated those specified by the Joint Commission, for instance; it requires that every patient's chart be screened for more than 50 quality indicators, and that intervention be swift and aggressive when necessary. We have established measurable standards of quality in every clinical department that must be met or exceeded. And, in a months-long project

completed earlier this year we even studied our hospital's mortality statistics, concluding they could not reliably be used as an indicator of quality or performance.

As HCFA itself has acknowledged, the December release of Medicare mortality data is profoundly limited as a yardstick of hospital quality that consumers can easily understand and compare. We encourage HCFA to clearly communicate such limitations, and to take whatever steps are necessary to eliminate confusion and apprehension among the general public and Medicare beneficiaries about the meaning and significance of this information.

We look forward to working with HCFA and other appropriate agencies which are developing systems for measuring hospital quality in meaningful ways, for the benefit of the people that we all serve.

Sincerely,

Gunther Seligmann
Chief Operating Officer

GS/mv
attachment

ATTACHMENT A

POUDRE VALLEY HOSPITAL

1986 MEDICARE PATIENT DEATHS
NOT IDENTIFIED BY HEALTHCARE FINANCING ADMINISTRATION

PATIENT ID NUMBER	SURNAME (First 6 Ltrs)	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINCIPAL DIAGNOSIS	PRINCIPAL PROCEDURE
[redacted]		PM	80	M		2/23/86	2/23/86	486	33.24
		GI	90	M		3/1/86	3/1/86	550.10	89.62
		HL	79	F		4/27/86	4/27/86	411.1	37.22
		CA	80	F		4/14/86	4/14/86	198.89	54.4
		PM	66	M		7/5/86	7/5/86	482.0	34.91
		UN	78	F		7/18/86	7/18/86	528.3	27.0
		HS	76	M		10/21/86	10/21/86	441.3	38.44
		UN	75	F		10/24/86	10/24/86	710.9	41.31
		CE	80			11/7/86	11/7/86	431	96.07
		UN	70			11/18/86	11/18/86	998.6	43.99
		PM	69			12/18/86	12/18/86	512.8	34.04

CO 59.2

October 26, 1987

Mr. Harvey Brock
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Meadows E. Building
6300 Security Blvd.
Baltimore, Maryland 21207

Dear Mr. Brock:

The HCFA generated mortality data recently sent to our organization has been analyzed by the AMI Rocky Mountain Healthcare System Medical Staff, Medical Records and Quality Assurance personnel. Our comments are addressing AMI Saint Luke's (Provider #06-0014) and AMI Presbyterian Denver and Aurora Hospitals (Provider #06-0005). The corrections are attached and we have the following comments regarding the HCFA mortality data provided to our facilities:

AMI Saint Luke's #06-0014

1. Many of the patients whose deaths were attributed to AMI Saint Luke's Hospital were elderly (over 75), entered the hospital with multiple medical problems and were designated as "Do Not Resuscitate" or taken off life support systems under the direction of their families while in the hospital.

   a. Seventy percent of the patients who died were 75 or older.

   b. Forty percent of the patients who died had three or more serious health problems; most entered the hospital in serious condition.

   c. Forty-eight percent of the patients who died were designated as "Do Not Resuscitate" or taken off life support systems by their families while in the hospital.

d. Forty-two percent of the patients who left the hospital had been transferred to a hospice or other appropriate facility for terminal treatment.

2. AMI Saint Luke's Hospital's patient population consists of a large, elderly Medicare group. The Senior Citizens' Health Center contributes heavily to the 42% level of Medicare patient population at AMI Saint Luke's Hospital. As discussed earlier, this population is generally very ill. The Medicare Case Mix Index at AMI Saint Luke's Hospital in 1986 was 1.4257, which indicates the high level of illness of the Medicare patient. The range in case mix for all patients in the city was .7973 - 1.2200.

3. Despite the percentage of Medicare patients and the compromised patient conditions, AMI Saint Luke's Hospital falls within the HCFA guidelines for expected mortality in all categories. The ranking for severe trauma at the upper limits of the guidelines can be attributed to AMI Saint Luke's Hospital's designation as a 911 emergency center, and the fact that severe trauma in many cases over the age of 65 leads to death. HCFA has included such diagnoses as hip fractures in its severe trauma category.

AMI Presbyterian Denver and Aurora Hospitals #06-0005

1. As with AMI St. Luke's Hospital, many of the patients whose deaths were attributed to AMI Presbyterian Denver and Aurora Hospitals were elderly (over 75) and entered the hospital with multiple medical problems.

   a. Sixty percent of the patients who died were 75 or older.

   b. Seventy-three percent of the patients who died had three or more serious health problems with 50% having five or more serious health problems. Seventy-three percent of the patients entered the hospitals in serious condition.

   c. Most of the patients who died were designated as "Do Not Resuscitate" or had life support systems removed by their families.

   d. Fifty-seven percent of those patients who left the hospital were placed in a nursing home or hospice situation.

2. The percentage of the patient population at AMI Presbyterian Denver and Aurora Hospitals that is made up of Medicare patients is even higher than at AMI St. Luke's - at 46.32%. The overall patient population at AMI Presbyterian Denver Hospital, including the Medicare patient population, is more severely ill than the patient populations of any other hospital of greater than 100 beds in the state of Colorado (see Colorado Health Data Commission Case Mix Index statistics). The Medicare Case Mix Index in 1986 at Presbyterian Denver and Aurora Hospitals was 1.3699, which is another indicator of the level of illness of the AMI Presbyterian Denver and Aurora Hospitals' patients. The range for the city, including all patients, was .7973 - 1.2200.

3. As with AMI Saint Luke's Hospital, AMI Presbyterian Denver and Aurora Hospitals have kept Medicare mortality rates within HCFA's guidelines, despite the severely ill nature of the patients. In the category of Sepsis, the mortality rate is at the high end, but one would expect a very high death rate with elderly septic patients.

Summary Comments for AMI Rocky Mountain Healthcare System #06-0014 and 06-0005

1. Mortality statistics can be a reflection of the quality of patient care given in a hospital, but more often reflect the condition of the patients as they enter the hospital, rather than what happens to them while in the hospital.

2. Our organization is committed to monitoring the quality of care in our facilities. Comprehensive chart review and other procedures are conducted by the hospital and medical staff in order to monitor our performance in providing patient care. We believe that a patient's well being is safe-guarded with these procedures. Our organization would be willing to answer questions regarding these procedures.

3. We have developed and have in place an Ethics Committee within the AMI Rocky Mountain Healthcare System. This Committee is consulted by the hospital and medical staffs and patient families regarding death and dying. The Committee was formed in order to help the above individuals achieve dignity in a situation where death is imminent. Death can, should, and of course, does occur in the hospital setting and sometimes a patient is admitted to die. This is necessary, in some cases, to maintain the integrity of the family unit.

Thank you for this opportunity to comment on the HCFA generated mortality statistics. If you or members of the general public have any questions, please contact me through the Medical Staff Office at (303) 839-6888.

Sincerely,

A. Lee Anneberg, M.D., Chairperson
Medical Quality Assurance Committee

ALA/SLR/mh

cc: J. Rock Tonkel, Group Vice President, American Medical International

Matt Kurs, Administrative Director, AMI Rocky Mountain Healthcare System

Paul Pretsch, Director of Marketing, AMI Rocky Mountain Healthcare System

Sally Robertson, Manager of Reimbursement Systems and Utilization Review, AMI Rocky Mountain Healthcare Systems

Leona Berger, Director of Professional Support Services, AMI Rocky Mountain Healthcare Systems

CORRECTIONS

AMI SAINT LUKE'S HOSPITAL #06-0014

PATIENT ID NUMBER (HIC)	PATIENT NAME	CORRECTION
[redacted]		Principal Procedure 92.24
		Principal Procedure 44.15
		Age 80
		Principal Procedure 45.13
		Date of Death 7/17/86
		Date of Death 7/29/86
		Age 87, Date of Death 9/15/86
		Age 67
		Date of Death 8/24/86, Principal Procedure 99.60
		Age 95
		Principal Diagnosis 157.0
		Change category from GI to CA
		Age 84
		Age 72
		Date of Death 2/26/86
		Age 72
		Age 70
		Date of Death 9/8/86
		Date of Death 8/30/86
		Principal Procedure 89.64
		Principal Procedure 37.72
		Date of Admission 1/2/86
		Principal Diagnosis 410.9
		Principal Procedure 99.60
		Date of Death 12/28/86
		Date of Discharge 7/21/86
		Date of Death 7/21/86
		Principal Diagnosis 482.1
		Date of Death 11/28/86
		Principal Procedure 38.93
		Principal Diagnosis 812.01
		Changes Category from TR to OP
		Date of Discharge 10/26/86
		Date of Death 10/26/86
		Date of Discharge 1/5/86
		Date of Death 1/5/86

CORRECTIONS

AMI PRESBYTERIAN DENVER AND AURORA HOSPITALS #06-0005

PATIENT ID NUMBER (HIC)	PATIENT NAME	CORRECTION
[redacted]		Date of Admission 6/4/86
		Date of Admission 6/22/86
		Date of Death 12/23/86
		Principal Diagnosis 038.43
[redacted]		Date of Death 8/6/86
		Date of Admission 12/30/86
		Date of Discharge 1/8/87
[redacted]		Date of Death 12/14/86
		Date of Discharge 11/2/86
		Date of Death 11/2/86
[redacted]		Date of Death 7/27/86
		Date of Death 10/1/86
		Principal Diagnosis 996.01
[redacted]		Never a patient at AMI Presbyterian Denver and Aurora Hospitals
		Date of Discharge 1/27/86
[redacted]		Date of Death 11/3/86

ROSE MEDICAL CENTER
OUR STANDARDS ARE SIMPLY HIGHER.

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and
Human Services
Health Care Financing Administration
Washington D.C. 20201

Hospital I.D. Number: 060032

Dear Dr. Roper:

Rose Medical Center is not able to verify the HCFA mortality data. Listed below are the differences between HCFA data and Rose Medical Center data.

	1986 # of Medicare Admissions	Patients who died at the Hospital	Patients who Died 30 days after Discharge
HCFA:	2191	148	58
Rose Medical Center:	3314	150	55

There was one patient who was indicated in the HCFA information to have died in the hospital that we found not to have died in the hospital. [redacted]. Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

One concern we have is that the information provided here will not be useful to the public and infact may be misleading because the ability of this model to detect differences in quality has never been evaluated. The mortality data can do no more than identify potential areas for further evaluation and cannot be used directly as a measure of hospital performance.

Sincerely,

Jeffrey A. Dorsey
Executive Vice President

Attachment

JAD;jld

cc: Sally Metzger

ST ANTHONY HOSPITAL SYSTEMS

CENTRAL: 4231 WEST 16TH AVENUE • DENVER, COLORADO • 80204 • (303) 629-3511
NORTH: 2551 WEST 84TH AVENUE • WESTMINSTER, COLORADO • 80030 • (303) 426-2151
SUMMIT MEDICAL CENTER: P.O. BOX 738 • FRISCO, COLORADO • 80443 • (303) 668-3300
EMERGENCY MEDICAL CENTER: P.O. BOX 952 • GRANBY, COLORADO • 80446 • (303) 887-2503

DOUGLAS R. COOK
President & Chief Executive Officer

October 22, 1987

Mr. Thomas G. Morford, Director
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: Beth Israel Hospital
Hospital #060019

Dear Mr. Morford:

Upon review of the attached mortality data, we find no gross errors to date. It is important that the range of predicted rates be explained to the public as accepted practice.

Please be advised that St. Anthony Hospital Systems acquired Beth Israel Hospital on September 1, 1987; therefore, this response is prepared by St. Anthony Hospital Systems on behalf of the former Beth Israel Hospital.

Thank you for your assistance in this matter.

Sincerely yours,

Douglas R. Cook
President & Chief Executive Officer

DRC/pkm

ST ANTHONY HOSPITAL SYSTEMS

CENTRAL: 4231 WEST 16TH AVENUE • DENVER, COLORADO • 80204 • (303) 629-3511
NORTH: 2551 WEST 84TH AVENUE • WESTMINSTER, COLORADO • 80030 • (303) 426-2151
SUMMIT MEDICAL CENTER: P.O. BOX 738 • FRISCO, COLORADO • 80443 • (303) 668-3300
EMERGENCY MEDICAL CENTER: P.O. BOX 952 • GRANBY, COLORADO • 80446 • (303) 887-2503

DOUGLAS R. COOK
President & Chief Executive Officer

October 20, 1987

Mr. Thomas G. Morford, Director
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: St. Anthony Hospital Systems
Hospital No. 060015

Dear Mr. Morford:

Upon review of the attached mortality data we find no gross errors to date. It is important that the range of predicted rates be explained to the public as accepted practice.

Thank you for your assistance in this matter.

Sincerely,

Douglas R. Cook
President and Chief Executive Officer

DRC/jw

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

SUBJECT: Medicare/Medicaid Provider Number 060028

Of the 309 patients listed, only 237 died at Saint Joseph Hospital. Seventy-two patients died after discharge somewhere else. Deaths after discharge could be unrelated to care provided in the hospital.

Thank you for the opportunity to respond. We, too, wish to produce data that is meaningful and accurate which will provide the public a means for well-informed decisionmaking.

Sincerely yours,

Sister Mary Andrew

Sister Mary Andrew
President

SMA:CPW

St. Joseph Hospital

600 West Third Street • Florence, Colorado 81226 • (303) 784-4891

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: COMMENTS ON THE HCFA MORTALITY DATA

TO WHOM IT MAY CONCERN

The following comments pertain to HCFA Mortality Data for 1986 for St. Joseph Hospital, Florence, Colorado. The first section pertains to verification of HCFA data, the second to interpretive remarks, unique services resulting in higher than average mortality is addressed in section III and results of preliminary Medicare record review is addressed in section IV.

I. Data Verification

The data used by HCFA indicate that a total of 23 Medicare patients admitted to St. Joseph Hospital died within 30 days of admission. Our records indicate that of the 23 Medicare patients who died within 30 days of admission, 5 were alive at the time of discharge, thus 18 died while an inpatient. Attached is a corrected copy of the patient listing clearly identifying any patients mistakenly coded (as dead) by HCFA at the time of discharge. Information concerning death after discharge is not included in the patient's medical record.

Our records indicate that 269 Medicare admissions occurred in 1986. HCFA reported 156 admissions. Based on hospital admission statistics the mortality rate for inpatients would compute to 7%. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to St. Joseph Hospital or any other hospital, counted only once for the most recent admission. We have no way of verifying whether the number of Medicare patients treated at other hospitals is correct.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the back-up diagnostic or other data used in the HCFA analysis.

II. Interpretive Remarks

In none of the diagnostic categories, does the St. Joseph Hospital actual mortality rate fall outside of the range of the predicted mortality rate.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

III. Unique Services Resulting in Higher than Average Mortality

St. Joseph Hospital did not experience a higher than predicted mortality rate. The mortality rate that is experienced at St. Joseph Hospital is due to a higher than average age of 78 years, co-morbidity complications of Medicare patients reported, and high risk chronic illnesses. Prognosis upon admission in each case was poor.

IV. Summary Results of Preliminary Medicare Record Review

The medical records were reviewed for each reported case with findings as follows:

A. All medical records listed on the data case list were reviewed. There were no diagnostic coding errors and disposition codes were correct, except for five patients who were alive at discharge, not dead as reported by HCFA. All patients included on the HCFA case listing were actually hospitalized; dates of admission, discharge and death were all accurate.

B. HCFA reported 156 admissions; actual Medicare admissions were 269. Numbers might vary as HCFA includes only the last admission for patients admitted to hospitals more than once during the year.

C. HCFA reported 23 deaths; however, actual in-hospital deaths numbered 18. Evidently 5 of the cases on the HCFA report were deaths occurring after the patient was discharged but within 30 days of hospitalization. This was reported verbally in follow-up with local nursing homes.

D. Actual mortality rate for each category did not fall lower than the lower end or higher than the upper end. There was not an unusually large percentage of deaths occurring after discharge per diagnostic category. All post discharge deaths were expected as all patients had poor prognosis while hospitalized and when discharged to nursing homes.

Please contact me if further information or clarification is necessary.

Sincerely,

Thomas W. Laux

Thomas W. Laux
Executive Vice President
Chief Operating Officer

js

ST. JOSEPH HOSPITAL-FLORENCE, COLORADO

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer				
CE -- Cerebrovascular Accidents	1			1
GC -- Gastrointestinal Catastrophes				
GI -- Gastrointestinal Disease	2		2	
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease	1			1
HM -- Severe Chronic Heart Disease	3		2	1
HS -- Severe Acute Heart Disease	4		4	
ME -- Metabolic/Electrolyte Disturbances				
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease	7		7	
RN -- Renal Disease				
SE -- Sepsis				
TR -- Severe Trauma				
OP -- Ophthalmalogic Disease				
UN -- Other Diagnoses	5		3	2
Total -- All Categories	23		18	5

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

HOSPITAL ID NUMBER 060045 CASE LIST OF PATIENTS STILL ALIVE WHEN DISCHARGED FROM HOSPITAL--DEATHS DID OCCUR

PATIENT ID NUMBER (HIC)	SURNAME (Last 6 ltrs	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINCIPAL DIAGNOSIS	PRIN. PROC.
[redacted]		CE	86	M	1-29-86	2-10-86	2-14-86	436	
[redacted]		HL	81	M	2-4-86	2-11-86	3-1-86	414.9	5732
[redacted]		HM	77	M	4-23-86	5-6-86	5-9-86	428.0	
[redacted]		UN	82	F	6-19-86	6-29-86	7-3-86	707.0	
[redacted]		UN	91	M	3-5-86	3-17-86	4-4-86	799.1	

CO 74.3

St. Joseph Hospital of the Plains
Cheyenne Wells, Colorado

Provider Number: 06-0043

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

ST. MARY-CORWIN HOSPITAL
REGIONAL MEDICAL & HEALTH CENTER

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

RE: Hospital Mortality Information

Dear Dr. Roper:

St. Mary-Corwin Hospital Regional Medical and Health Center appreciates the opportunity to provide comments on the Health Care Financing Administration's 1986 mortality data. Please note appended comments. We would anticipate these comments would be included with the anticipated December, 1987 release of the data to the public.

Thank you for your attention to this matter.

Sincerely,

William G. Turman M.D.

William G. Turman, M.D.
Executive Vice President

Enclosure (1)

xc: Edmond T. Doyle
Executive Vice President
Sister of Charity Healthcare Systems, Inc.

In December 1987, the Health Care Financing Administration (HCFA) plans to publish selected mortality information about all short term acute care hospitals which treated Medicare patients in 1986. So that the documents to be published in December reflect the most accurate information available, we are asking hospital administrators to review the information about Medicare experience in their individual hospitals and to provide comments to HCFA.

The following information presents mortality information about Medicare patients treated in your hospital in 1986. The statistics show the number of Medicare patients admitted, the actual percent of those patients who died within 30 days of their last admission of 1986, and a predicted range of the percent of patients who would have been expected to die given adjustments for patient mix. These three items are presented on both an overall basis and for each of 16 diagnostic categories. In December, we plan to publish this information for all hospitals.

HOSPITAL = 060012 **ST MARY CORWIN HOSPITAL** **PUEBLO, CO**

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATE
ALL CAUSES	2,577	12%	9 TO 15%
CA - CANCER	231	27%	19 TO 35%
CE - CEREBROVASCULAR ACCIDENTS	75	13%	18 TO 39%
EY - OPHTHALMOLOGIC DISEASE	7	0%	0 TO 100%
GC - GASTROINTESTINAL CATASTROPHIES	58	36%	11 TO 34%
GI - GASTROINTESTINAL DISEASE	248	8%	3 TO 10%
GU - UROLOGIC DISEASE	151	1%	1 TO 11%
GY - GYNECOLOGIC DISEASE	36	0%	0 TO 57%
HL - LOW-RISK HEART DISEASE	191	5%	2 TO 9%
HM - SEVERE CHRONIC HEART DISEASE	90	32%	16 TO 34%
HS - SEVERE ACUTE HEART DISEASE	105	36%	29 TO 49%
ME - METABOLIC/ELECTROLYTE DISTURBANCES	41	17%	8 TO 35%
OP - ORTHOPEDIC DISORDERS	256	3%	0 TO 4%
PN - PULMONARY DISEASE	172	17%	14 TO 29%
RN - RENAL DISEASE	30	23%	8 TO 45%
SE - SEPSIS	42	36%	23 TO 54%
TR - SEVERE TRAUMA	99	7%	4 TO 17%

Of the 2,577 Medicare admissions as reported by HCFA, 304 deaths were identified as occurring within 30 days of admission.

All 304 deaths reported by HCFA were reviewed for accuracy regarding admission and discharge dates. In only one (1) case were we unable to confirm the admission to this institution, therefore, we would anticipate the number of deaths ·ld be adjusted to 303.

58 of the 303 cases were reported to have expired sometime after discharge, but within 30 days of admission to the hospital. Upon further review, three (3) of these 58 cases actually expired while in the hospital. Furthermore, at least eight (8) of the 58 cases died during their stay in our Extended Care Facility following hospitalization.

Clarification of the reported actual mortality rates in four (4) diagnostic categories need be made. Seventeen (17) deaths among 248 cases in the gastrointestinal category is 7% vs 8%. For the severe chronic heart disease category 30 deaths among 90 cases results in an actual mortality rate of 33 vs 32%. In the sepsis category 13 reported deaths among 42 cases results in an actual mortality rate of 31% vs 36%. Lastly, five (5) deaths among 99 reported cases in the severe trauma category is an actual mortality rate of 5% vs 7%.

Preliminarily, five (5) diagnostic categories were selected for focused review. Among the categories selected 89 deaths were reported among 694 cases. Of the 89 deaths, 56 or 63% of the cases were reviewed.

Of the five diagnostic categories selected, reviews were done for those deaths that occurred in the following diagnostic categories: gastrointestinal catastrophies, severe chronic heart disease, sepsis, gastrointestinal disease, and orthopedic disorders.

Among the deaths in the gastrointestinal catastrophies category, 21 deaths were reported among 58 cases, for an actual mortality rate of 36% with a predicted mortality rate of 11 to 34%. Upon review, coding issues were raised in three (3) of the cases. Appropriate recording would redistribute these three cases among other diagnostic categories. This would then produce an adjusted actual mortality rate for this category of 31%. Two (2) cases were reported to have occurred post discharge. However, on further review it was confirmed that in one (1) case death occurred during hospitalization with the other case returning to a nursing home, death was not unexpected in either case. Of the other cases, three (3) were transfers from local nursing homes and two (2) from outlying hospitals. Death was the expected outcome given the advanced state of each patient's disease process or condition at the time of admission or course during hospital stay. Of further note, at least four (4) families requested that no heroic measures be initiated in light of the patient's poor prognosis.

In the severe chronic heart disease category, 30 deaths were reported among 90 cases, with an actual mortality rate of 32% within a predicted mortality range of 16 to 34%. As indicated previously this rate recalculated is 33 vs 32%. Coding issues were raised in two (2) cases. With appropriate recoding these cases would be redistributed among other diagnostic categories, producing an adjusted actual mortality rate of 31%. Of the eight (8) cases reported to have died post discharge, one (1) patient actually died while hospitalized. Of those that died after discharge two (2) were admitted from and returned to local nursing homes, their deaths were not unanticipated. Another case, though not admitted from a nursing home was transferred to a local facility after discharge where death was imminent. Among those deaths that occurred during hospitalization one (1) patient transferred from a local nursing home with two (2) other cases that transferred from outlying hospitals. One of these patients was a transfer following cardiopulmonary arrest. Review of these cases would indicate that death was not an unexpected outcome. At least four (4) families requested no heroic measures be initiated to prolong life.

There were 17 deaths among 248 cases in the gastrointestinal category. Our actual mortality rate is reported at 8% within a predicted mortality rate of 3 to 10%. No coding issues were raised among those cases reviewed. Three (3) cases died after discharge (one of these in a local nursing home). Further review needed in order to determine if these deaths were anticipated. The other reported deaths were not unanticipated with one (1) case a transfer from an outlying hospital. In two (2) cases the patient's medical condition precluded any surgical intervention, it was anticipated that neither patient would survive surgery. In at least one (1) case the family requested no heroic measures.

In the orthopedic disorders category our actual mortality rate was reported at 3%, 8 deaths among 256 cases. The predicted mortality rate range for this category is 0 to 4%. No coding questions were raised among those cases reviewed. Death was not unexpected in these cases due to the condition of the patients at admission or their course during hospital stay.

Among the deaths in the sepsis category the rate is reported at 13 deaths among 42 cases with an actual mortality rate of 36% within a predicted mortality range of 23-54%. Upon recalculation 13 reported deaths among 42 cases results in an actual mortality rate of 30%. Among the 13 deaths seven (7) occurred post discharge. In one (1) case an issue of coding is raised and with appropriate recoding this case would be reassigned to another diagnostic category. This reassignment in turn would result in an actual mortality rate of 29%. At least six (6) of the patients were transfers from local nursing homes, of these, four (4) returned to the nursing homes following discharge. In another case hospice care arrangements were made post discharge. Death was not unexpected in any of the cases reviewed.

Our preliminary review of the HCFA mortality information reinforces the understanding that this institution serves as a regional referral center, in particular given the moribund or near moribund condition of a number of the patients reported among our mortalities.

ST. THOMAS MORE HOSPITAL
AND
PROGRESSIVE CARE CENTER

1019 Sheridan Street
CANON CITY, COLORADO 81212
303/275-3381

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

We have reviewed the mortality information on this hospital. Please note the discrepancies that we have discovered and please make corrections accordingly.

COMMENTS:

Patient with [redacted] - This patient's death date is incorrect. The patient actually died in this hospital on 9/17/86. You have the death date as 9/30/86.

Patient with [redacted] - This patient's death date is incorrect. The patient actually died in this hospital's ECF unit on 11/10/86. You have the death date as 11/11/86.

Patient with [redacted] - This patient's death date is incorrect. The patient actually died in this hospital's ECF unit on 6/27/86. You have the death date as 6/30/86.

It is important for the public to understand that these mortality rates published by HCFA are not, in themselves, measures of hospital performance. Under no circumstances should they be used as the basis for judging the quality of care provided by different hospitals.

The number of "cases" included in the HCFA analysis is 599. Our records indicate that 818 Medicare admissions occurred in 1986. These numbers differ because HCFA includes only the last admission for patients that were admitted more than once during the year.

Though HCFA has made available to hospitals data for verification prior to publication, it is unlikely that hospitals will be able to verify 100% of the data. The time that would have to be taken to verify the deaths of patients that died after discharge goes against what hospitals are supposed to be doing, and that is containing costs. This is data that hospitals cannot verify 100%, thus the data published should be questioned for validity.

Another question that arises is the fact that the cause of the patient's death could be unrelated to the reason for that patient's last hospitalization (ex: vehicle accident).

In the fifth paragraph of HCFA'a letter to the hospital administrators they used the term "death rate". Hospital Death Rates have always been computed by dividing the number of deaths of inpatients in a period by the number of discharges, including deaths, in the same period and multiplying the quotient by 100.

The hospital death rate HCFA is referring to is not only taking inpatient deaths into account, but also deaths that occurred after the patient was discharged. This is not what has been accepted as the "hospital death rate".

Thank you for your attention to these corrections and comments.

Sincerely,

Paul A. Masar

Paul A. Masar
Interim Administrator

Linda Mondragon

Linda Mondragon
Medical Records Director

Swedish Medical Center

501 East Hampden Avenue
P.O. Box 2901
Englewood, Colorado 80110-2796
(303) 788-5000

October 9, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper,

Thank you for the opportunity to respond to the planned release of hospital mortality statistics. I offer this letter on behalf of

Swedish Medical Center
Englewood, Colorado
Hospital #060034

1) The patients selected on your list were all, in fact, inpatients at Swedish Medical Center in 1986.

2) Our overall "All Causes" mortality rate is 9.4% which rounds off to 9% rather than 10% as shown on your report.

3) 24% of the cases identified in your data died post discharge from Swedish Medical Center.

-Of those patients 26.5% had been reviewed and approved by our local PRO.

-An additional 37% were patients who were "do not resuscitate" status. This status is given to patients who request no life saving measures be provided or who have family members or legal guardians who, acting on their behalf, have requested this status. This status obviously indicates that death is basically imminent.

4) The average age of the patients in your data base on Swedish is 80.01 years. The average life expectancy in the U.S. today is 74.7 years.

These numbers stand on their own merit without entering the lengthy discussion of severity of illness. Obviously the type of patient a tertiary institution, such as Swedish, sees has a significant impact on a statistic as gross as the overall mortality indicator. We encourage a recognition of this variable as continued public awareness activities are pursued by the Department of Health and Human Services.

Thank you again for the opportunity to review this data and to offer our comments.

Sincerely,

Kenneth E.S. Platou
Assistant Administrator

cc: Nick Hilger

Union Printers Home HOSPITAL AND HOME FOR THE AGED

ROBERT S. McMICHEN, *President*
BILLY J. AUSTIN, *Vice-President*
THOMAS W. KOPECK, *Secretary-Treasurer*
Trustees:
WILLIAM J. BOARMAN
FRED LEATHEM
DONALD M. FIFIELD, *Administrator*

FOUNDED IN 1892
101 SOUTH UNION BLVD
COLORADO SPRINGS,
COLORADO 80910
(303) 634-3711

October 16, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Attention: William 1. Roper, M.D.
Administrator

Re: 1986 Mortality information

Dear Dr. Roper:

The two deaths listed for [redacted] are correct.

Our records indicate ten Medicare admissions in 1986 for our Hospital Unit. We question why your figures show only seven admissions.

We also question the worth of making any Range of Predicted Mortality Rates on such a small sample. Case in point (using your figures): There were four hospital admissions with a diagnosis of Pulmonary Disease with a 0% Actual Mortality Rate.... how can anyone predict a Mortality Rate of between 4% and 78%?

It is herewith suggested that careful consideration be given to the appropriateness of publishing any figures for this facility.

Yours truly,

Donald M. Fifield
Administrator

DMF/mw
Enclosure

cc: Larry Wall, President
Colorado Hospital Association

University of Colorado Health Sciences Center

4200 East Ninth Avenue
Denver, Colorado 80262

University Hospitals
School of Medicine

School of Nursing
School of Dentistry

School of Pharmacy
Graduate School

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

University Hospital has reviewed the mortality statistics which HCFA plans to publish in December and would like to submit the following comments and changes to be made before final publication.

The data used by HCFA indicate that a total of 139 Medicare patients admitted to University Hospital died within 30 days of admission. Of these, 103 died while still a patient of the hospital while 36 died after discharge.

In carefully checking our medical records and billing documents, we discovered that the following changes need to be made for the HCFA Mortality Report data to be accurate.

1. Cancer:
   A. One patient should be changed from the Pulmonary to the Cancer category due to corrected billing being submitted in November 1986. Statistics would then reflect twelve in-hospital and eleven post-hospital deaths and a 23% mortality rate.

   B. Of the eleven post-hospital deaths, eight were discharged to a hospice for terminal care.

2. Cerebrovascular Accidents:
   A. One patient should be changed from the Low Risk Heart Disease to the Cerebrovascular accident (CE) category due to a data entry error on the part of the fiscal intermediary (FI) in billing.

   B. A second patient should be deleted from the CE category and added to the Severe Acute Heart Disease category due to corrected billing submitted in October 1986.

   C. Dates of death are in error on two patients; both died in the hospital.

   D. Statistics should reflect five in-hospital deaths.

The University of Colorado is an equal opportunity / affirmative action employer

3. Severe Acute Heart Disease:
   A. Three patients should be added to this category from the Low Risk Heart Disease category due to fiscal intermediary data entry errors in dropping the principal diagnosis code.

   B. One patient should be added from the Cerebrovascular Accident category (see # 2.B.).

   C. The resulting statistics would be changed to twelve in-hospital deaths, three post-hospital deaths, and a mortality rate of 46%.

4. Metabolic and Electrolyte Disorders:
   A. One patient should be changed to the "Other" category due to corrected billing submitted in October 1986 reflecting patient had viral hepatitis with hepatic coma.

   B. Statistics should reflect "zero" deaths with 0% mortality rate.

5. Pulmonary Disease:
   A. One patient shown as a post-hospital death was transferred to the Veteran's Administration Medical Center. Patient was confirmed to have expired there and should be deleted from the cases.

   B. One patient should be deleted from Pulmonary and added to Cancer category (see # 1.A.).

   C. Statistics would then reflect sixteen in-hospital deaths, two post-hospital deaths and 22% mortality rate.

6. Renal Disease:
   A. One patient was transferred to a specialty hospital to treat a respiratory problem; specialty hospital confirmed that he died there. Case should be deleted from post-hospital deaths.

   B. Statistics should be changed to reflect one in-hospital death, three post-hospital deaths and a 7% mortality rate.

7. Low Risk Heart Disease:
   A. Four patients are in this category in error and should be changed appropriately (see # 2.A. and 3.A.).

   B. Statistics should then reflect eleven in-hospital deaths, two post-hospital deaths and a 10% mortality rate.

Attached are our documents from which these recommendations were made. We would like to note that statistical analyses of mortality rates can do no more than suggest thorough review of medical records. Clearly they cannot of themselves indicate quality of care.

Because we are a university teaching hospital, we serve as a tertiary care referral center for Colorado and the surrounding states for severely ill patients. The great majority of patients are referred to us because of the complexity of the clinical situation involved. We have a large referral pattern in many clinical areas of patients with advanced disease. These circumstances lead to the potential for our hospital having an above average mortality rate.

We respectfully request that HCFA respond to the above information in order to ensure a fair and accurate HCFA report.

Sincerely,

James H. Shore

James H. Shore, M.D.
Interim Director
University Hospital

UNIVERSITY HOSPITAL-DENVER, COLORADO
HCFA DATA

Diagnostic Category	# Cases	# Deaths In-Hosp	# Deaths Post-Hosp	Mort. Rate	Predicted Range	Footnotes
CA - Cancer	101	12	10 (2)	24% (1)	18-39%	(1) Error-% should read "22%" according to figures given.
						(2)A. 1 pt. should be added from "PN" (See Footnote 6). Statistics would then reflect 11 post-hospital deaths & 23% mort. rate.
						B. Of 11 pts. expiring post-discharge: 8 were discharged to a hospice for terminal care.
CE - Cerebrovascular accidents	27	5 (3)	0	19%	13-46%	(3)A. Dates of death (DOD) are in error on 2 pts.: [redacted] DOD:8/9 (not 8/10) [redacted] - DOD:4/24 (not 4/25) Pts. both died in hospital.
						B. 1 pt. from "HL" category should be added to "CE" category (FI data entry error): [redacted] 1/25-Prin.DX Code:431 1 pt. from "CE" category should be changed to "HS" category (bill resubmitted in 10/86): [redacted] DOD 6/5. Statistics remain the same.
GC - Gastrointestinal catastrophes	19	5	0	26%	5-41%	

CO 83.3

HCFA DATA-PAGE 2

Diagnostic Category	# Cases	# Deaths In-Hosp	# Deaths Post-Hosp	Mort. Rate	Predicted Range	Footnotes
HS - Severe acute heart disease	41	12 (4)	3	39%	24-54%	(4) A.1 pt. should be added from "CE" (see footnote 3.B.). B.3 pts. should be added from "HL" category (due to PI data entry errors): [redacted] DOD 2/6;prin.dx code-410.4 [redacted] DOD 3/24;prin.dx code-410.3 [redacted] DOD 3/24; prin. dx code-427.1 C.Resulting statistics: 16 in-hospital deaths-Mort. Rate: 46%
HM - Severe chronic heart disease	30	3	2	17%	9-39%	
ME - Metabolic and electrolyte disorders	22	1 (5)	0	14%	3-37%	(5)1 pt. should be changed to "UN" category: [redacted] DOD 2/4: bill submitted with erroneous codes-Corrected billing submitted 10/86-Prin. Dx Code: 070.2-Viral hepatitis with hepatic coma. Pt. also had chronic hepatitis, hepatorenal syndrome, GI hemorrhage, and septicemia. Based on 1 death out of 22 cases=5% not 14%, as HCFA shows. Statistics should reflect "0" deaths with 0% mortality rate.

CO 83.4

HCFA DATA-PAGE 3 Diagnostic Category	# Cases	# Deaths In-Hosp/Post-Hosp		Mort. Rate	Predicted Range	Footnotes
PN - Pulmonary Disease	83	16	4 (6)	27%	9-26%	(6) 1 pt. should be changed to "CA" category: [redacted]-DOD 5/24-Corrected billing submitted 11/86-Prin. DX Code-182.0(Malignant neoplasm of corpus uteri). 1 pt. was transferred to Veteran's Admin. Medical Center and died there. (verified by VAMC): [redacted]-DOD 5/30-pt. should be deleted from hospital's cases. **Statistics should reflect 2 post-hospital deaths and 22% mortality rate.**
RN - Renal Disease	59	1 (7)	4	8%	2-34%	(7) 1 pt. was transferred to National Jewish Hospital to treat COPD & died there 7 days later (verified by NJH). [redacted]-DOD 7/29. Pt. should be deleted from hospital's cases. **Statistics should reflect 3 post-hospital deaths & 7% mortality rate.**
SE - Sepsis	7	4	1	71%	14-78%	
TR - Severe trauma	21	0	1	5%	1-30%	
EY - Ophthalmologic Disease	7	0	0	0%	0-100%	

CO 83.5

Diagnostic Category	# Cases	# Deaths In-Hosp	# Deaths Post-Hosp	Mort. Rate	Predicted Range	Footnotes
GY - Gynecologic Disease	15	0	0	0%	0-92%	
HL - Low Risk Heart Disease	94	11 (8)	2	14%	2-12%	(8) 4 deaths in wrong category (See Footnotes 3.B. and 4.B.) Statistics should reflect 7 in-hospital deaths and 10% mort. rate.
GU - Urologic Disease	29	0	0	0%	0-24%	
OP - Orthopedic Conditions	63	0	0	0%	0-13%	

Yuma District Hospital

910 South Main — Yuma, Colorado 80759 — Phone 848-5405

James D. Naeve, Administrator

October 21, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Review of the mortality data for Yuma District Hospital, I.D. Number - 060056, indicates that in all diagnostic categories except one the actual mortality rate falls well within the range of predicted mortality rates.

In the CA - Cancer category, where the actual mortality rate exceeds the range of predicted mortality rates, we had two patients during 1986. Both of these patient were in a very advanced stage of the disease at the time of admission. Both patients had been treated at other hospitals and on an outpatient basis here during the earlier stages of disease and were essentially terminal at the time of admission to Yuma District Hospital.

It is likely that any future cancer patients that we might have will also have the majority of their care at a larger facility as well.

Sincerely,

James D. Naeve

James D. Naeve, Administrator

Connecticut

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BRADLEY MEM HOSP SOUTHINGTON CT 06489	CT-5 *	779	11	9-17	40	23	13-42	38	16	16-45	12	25	6-53	55	15	14-37	30	33	24-59	13	8	7-52	82	17	10-29
BRIDGEPORT HOSPITAL BRIDGEPORT CT 06602	CT-6	3564	11	9-15	351	22	16-30	155	28	20-36	82	18	10-30	196	23	16-29	153	36	30-47	74	19	9-31	253	19	14-27
BRISTOL HOSP BRISTOL CT 06010	CT-7 *	1743	12	10-17	160	24	18-36	72	26	18-40	42	17	8-34	118	25	16-32	65	42	27-51	32	22	10-42	168	18	15-30
CHARLOTTE HUNGERFORD HOSP TORRINGTON CT 06790	CT-8	1522	12	10-17	103	27	17-38	56	38	18-43	39	23	9-36	86	22	15-33	59	32	27-53	29	24	7-38	142	17	14-29
DANBURY HOSP DANBURY CT 06810	CT-9	2975	12	9-15	242	30	18-34	79	32	20-41	56	16	7-29	154	25	17-31	90	41	29-50	57	19	7-30	259	22	14-27
DAY KIMBALL HOSPITAL PUTNAM CT 06260	CT-10	1316	12	9-16	100	25	14-33	58	40	18-41	27	30	7-38	84	17	12-30	62	37	26-51	33	3	5-33	154	17	12-27
GREENWICH HOSP ASSN GREENWICH CT 06830	CT-11	1836	12	10-17	196	24	18-35	72	32	20-42	47	23	9-34	99	18	16-34	66	33	28-53	22	18	9-45	155	24	17-33
GRIFFIN HOSP DERBY CT 06418	CT-12	1610	13	10-17	124	23	15-34	81	26	18-38	52	17	11-36	110	20	15-32	76	34	25-48	48	27	12-38	122	19	12-28
HARTFORD HOSP HARTFORD CT 06106	CT-13	6674	11	9-15	717	20	18-31	207	24	21-36	109	20	13-32	314	24	18-28	305	31	32-45	70	29	10-32	413	21	15-26
JOHN DEMPSEY HOSP FARMINGTON CT 06032	CT-14	916	10	8-16	68	24	19-43	42	14	16-43	23	9	8-42	26	19	13-46	32	31	24-57	17	41	14-58	49	24	12-36
JOHNSON MEM HOSP STAFFORD SPRINGS CT 06076	CT-15 *	625	10	10-18	21	24	15-55	21	19	13-50	20	15	6-42	34	12	10-38	27	26	24-60	23	35	10-47	85	15	13-31
LAWRENCE MEM HOSPS NEW LONDON CT 06320	CT-16	2637	12	9-15	216	24	16-31	95	31	19-38	69	29	10-31	132	19	15-31	110	38	30-49	45	18	8-34	223	17	14-27
MANCHESTER MEM HOSP MANCHESTER CT 06040	CT-17 *	2038	13	11-17	170	22	18-36	67	33	20-43	49	27	10-35	121	26	16-31	105	30	29-49	49	20	9-35	166	25	16-31
MERIDEN-WALLINGFORD HOSPIT MERIDEN CT 06450	CT-18 *	1636	13	10-17	154	23	15-32	75	21	19-40	31	13	8-38	86	26	14-33	66	35	27-52	49	16	10-37	120	19	14-30
MIDDLESEX MEM HOSP MIDDLETOWN CT 06457	CT-19	2864	14	10-17	242	24	16-32	139	28	21-37	64	23	9-30	172	22	16-30	147	35	31-49	85	18	11-33	246	25	15-28
MILFORD HOSPITAL MILFORD CT 06460	CT-20 *	992	12	10-17	86	20	13-34	48	23	17-43	31	23	10-40	58	16	14-36	43	35	22-52	9	33	5-59	99	22	14-32
MT SINAI HOSP HARTFORD CT 06101	CT-21	1745	12	10-17	115	16	15-34	51	31	16-41	33	15	10-40	111	21	18-35	57	53	28-54	59	29	14-39	153	19	15-30
NEW BRITAIN GEN HOSP NEW BRITAIN CT 06050	CT-22	3269	12	10-16	272	22	16-31	172	21	21-36	70	24	11-33	178	22	17-30	145	34	31-49	52	42	14-40	259	24	16-29
NEW MILFORD HOSP NEW MILFORD CT 06776	CT-23	785	10	8-15	45	29	12-38	21	29	13-51	20	10	8-46	43	19	11-36	19	16	20-63	13	23	6-51	82	20	12-31
NORWALK HOSPITAL NORWALK CT 06856	CT-24	2690	10	10-16	263	22	16-32	97	28	20-39	69	22	11-33	153	18	17-31	127	26	31-50	36	14	8-36	182	15	15-29
PARK CITY HOSP BRIDGEPORT CT 06604	CT-25	574	8	7-15	38	21	9-37	16	19	10-52	20	5	6-43	31	13	11-41	11	27	17-70	16	13	4-43	40	18	10-37
ROCKVILLE GENERAL HOSP ROCKVILLE CT 06066	CT-26 *	871	11	9-16	68	26	14-38	38	24	17-47	17	18	7-47	52	13	11-34	31	32	22-56	15	20	8-52	68	13	10-30
SHARON HOSPITAL SHARON CT 06069	CT-27 *	777	11	9-17	55	24	13-38	29	24	14-47	22	9	7-41	53	21	12-35	40	43	25-56	16	19	6-47	85	11	10-28
ST FRANCIS HOSP HARTFORD CT 06105	CT-28	4629	11	9-15	437	19	17-30	137	24	22-38	98	19	11-29	222	19	18-30	143	38	30-48	63	17	11-34	355	21	16-28
ST JOSEPHS HOSP STAMFORD CT 06904	CT-29	1260	4	7-14	92	9	12-32	30	13	15-47	29	10	7-37	78	4	13-32	37	11	23-55	16	19	8-50	75	4	10-29
ST MARYS HOSP WATERBURY CT 06702	CT-30	3135	14	10-16	298	23	16-31	131	24	21-38	82	21	11-31	168	26	16-30	136	36	32-50	41	51	11-40	243	28	16-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BRADLEY MEM HOSP SOUTHINGTON CT 06489	12	33	8-59	15	47	14-61	24	4	2-29	3	0	0-100	81	2	2-13	47	2	1-18	9	0	0-85	85	2	2-12	39	3	0-18
BRIDGEPORT HOSPITAL BRIDGEPORT CT 06602	21	14	8-49	28	32	20-57	99	5	4-16	24	0	0-65	347	4	3-8	145	1	1-11	36	0	0-79	388	5	3-8	218	1	0-5
BRISTOL HOSP BRISTOL CT 06010	10	20	3-55	11	36	13-66	34	9	4-28	13	0	0-80	200	3	3-10	71	1	2-15	14	0	0-59	140	3	2-10	53	2	1-14
CHARLOTTE HUNGERFORD HOSP TORRINGTON CT 06790	9	11	2-58	10	40	15-71	42	7	4-25	4	0	0-100	142	7	3-12	69	1	1-15	15	0	0-67	101	7	2-12	83	1	0-9
DANBURY HOSP DANBURY CT 06810	18	17	8-51	19	26	16-58	91	3	4-18	10	0	0-96	272	5	3-9	151	10	3-13	20	0	0-93	251	4	3-8	214	0	0-5
DAY KIMBALL HOSPITAL PUTNAM CT 06260	10	20	6-61	4	0	6-81	44	7	3-23	3	0	0-100	142	5	3-11	60	0	1-16	17	0	0-95	122	3	2-10	63	0	0-11
GREENWICH HOSP ASSN GREENWICH CT 06830	13	38	10-60	11	18	15-68	59	5	4-20	24	0	0-81	183	3	3-10	66	2	1-15	15	0	0-91	133	8	2-11	138	1	0-6
GRIFFIN HOSP DERBY CT 06418	8	25	4-62	15	47	18-66	62	8	3-19	1	0	0-100	188	6	3-10	83	7	2-14	23	0	0-49	115	4	2-11	62	2	0-12
HARTFORD HOSP HARTFORD CT 06106	45	27	12-45	30	40	23-60	201	8	5-15	128	1	0-6	653	5	4-8	360	7	2-10	78	1	0-12	651	4	3-7	540	0	1-4
JOHN DEMPSEY HOSP FARMINGTON CT 06032	8	25	7-66	12	33	14-66	26	0	1-26	3	0	0-100	63	3	2-15	27	7	1-26	7	0	0-100	73	4	1-12	86	2	0-9
JOHNSON MEM HOSP STAFFORD SPRINGS CT 06076	4	0	3-78	5	40	6-75	14	0	2-39	5	0	0-100	63	3	2-15	17	0	1-34	13	0	0-97	68	4	2-14	29	7	0-21
LAWRENCE MEM HOSPS NEW LONDON CT 06320	17	18	9-54	33	6	23-58	113	12	5-18	17	0	0-71	270	4	2-8	100	2	1-13	24	0	0-89	201	6	2-8	164	3	0-6
MANCHESTER MEM HOSP MANCHESTER CT 06040	15	33	11-59	23	48	23-63	68	4	5-21	33	0	0-29	227	5	3-10	85	2	1-13	18	0	0-84	150	1	3-10	86	0	0-9
MERIDEN-WALLINGFORD HOSPIT MERIDEN CT 06450	15	20	9-56	30	30	19-55	51	6	3-21	10	0	0-90	212	9	4-11	76	1	1-14	18	0	0-94	101	3	2-11	73	1	0-10
MIDDLESEX MEM HOSP MIDDLETOWN CT 06457	15	13	8-54	40	48	23-55	114	9	5-17	20	0	0-45	310	4	3-8	119	7	1-12	39	0	0-59	202	5	3-9	126	2	0-7
MILFORD HOSPITAL MILFORD CT 06460	5	0	3-72	15	33	14-61	32	0	3-26	7	0	0-100	107	11	3-13	42	0	1-19	3	0	0-97	73	3	2-13	37	0	0-20
MT SINAI HOSP HARTFORD CT 06101	9	22	4-60	6	17	10-76	48	8	4-23	12	0	0-99	144	4	2-11	104	9	3-15	9	0	0-69	156	6	3-11	73	1	0-10
NEW BRITAIN GEN HOSP NEW BRITAIN CT 06050	23	26	14-56	9	22	8-64	80	10	4-19	63	0	0-18	335	3	3-8	154	5	2-12	34	0	0-32	259	3	2-8	184	2	0-5
NEW MILFORD HOSP NEW MILFORD CT 06776	3	33	1-82	7	0	12-75	36	6	2-23	8	0	0-99	76	1	1-13	31	3	1-23	7	0	0-100	60	8	2-14	61	0	0-12
NORWALK HOSPITAL NORWALK CT 06856	15	13	8-55	22	23	18-58	97	5	3-15	32	0	0-49	238	4	3-10	114	1	1-12	12	8	0-83	198	4	2-9	150	3	1-7
PARK CITY HOSP BRIDGEPORT CT 06604	6	17	2-67	7	14	12-75	14	0	2-39	3	0	0-100	48	6	1-17	30	3	1-23	.	.		46	4	1-16	26	0	0-32
ROCKVILLE GENERAL HOSP ROCKVILLE CT 06066	11	27	11-66	5	20	7-77	21	5	4-35	14	0	0-89	116	8	3-13	36	0	0-21	3	0	0-100	77	3	2-13	59	2	0-12
SHARON HOSPITAL SHARON CT 06069	2	0	4-92	.	.		26	4	3-29	3	0	0-100	85	1	2-13	44	2	1-19	7	0	0-89	58	7	1-14	35	0	0-20
ST FRANCIS HOSP HARTFORD CT 06105	33	21	11-48	40	33	24-57	126	6	5-17	60	0	0-15	498	6	4-9	182	5	2-11	46	2	0-29	621	4	4-8	226	1	1-5
ST JOSEPHS HOSP STAMFORD CT 06904	5	0	1-71	13	15	11-59	42	7	2-20	20	0	0-77	154	1	2-10	54	0	1-16	7	0	0-100	116	3	2-10	66	3	0-11
ST MARYS HOSP WATERBURY CT 06702	31	13	10-47	19	47	22-66	115	5	4-16	29	0	0-43	373	6	3-9	161	12	3-13	24	0	0-83	269	3	3-8	173	2	1-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST VINCENTS MED CTR BRIDGEPORT CT 06606	CT-31	3250	13	10-17	263	25	17-32	136	28	20-37	101	18	13-32	173	21	16-29	179	39	30-46	72	22	10-32	222	25	17-31
STAMFORD HOSPITAL STAMFORD CT 06902	CT-32	1586	11	9-16	142	29	16-34	57	32	18-43	44	7	7-32	96	19	16-34	59	36	27-53	41	17	11-40	109	18	13-30
THE CT HOSPICE INC BRANFORD CT 06405	CT-33 *	2	100	3-91	2	100	3-91	.	.		.	.		.	.		.	.		.	.		.	.	
THE HOSPITAL OF ST RAPHAEL NEW HAVEN CT 06511	CT-34 *	4640	12	10-17	504	18	17-30	153	31	21-37	125	15	13-31	273	23	18-30	207	38	32-47	63	22	10-33	362	25	17-29
VA HOSP WEST HAVEN CT 06516	CT-35 *	6	0	0-63	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
WATERBURY HOSP WATERBURY CT 06720	CT-36	2251	10	8-15	232	14	14-30	78	24	19-40	56	11	8-30	103	19	14-30	95	44	27-48	38	11	7-34	140	22	12-27
WILLIAM W BACKUS HOSP NORWICH CT 06360	CT-37	1931	14	9-16	150	25	16-34	83	36	19-40	34	9	7-35	115	28	15-32	68	34	28-52	31	26	7-38	207	21	14-27
WINDHAM COMM MEM HOSP WILLIMANTIC CT 06226	CT-38	1009	12	9-16	58	29	14-39	38	34	15-44	23	13	6-39	56	20	14-37	44	27	27-57	19	26	10-50	113	25	12-29
WINSTED MEM HOSP WINSTED CT 06098	CT-39	471	14	10-19	25	44	14-50	17	18	11-53	15	27	5-46	35	14	11-39	22	32	21-60	7	14	6-66	62	16	11-33
WW2 VETERANS MEM HOSP MERIDEN CT 06450	CT-40 *	710	10	8-16	37	19	11-39	29	28	14-46	12	17	6-53	44	18	12-37	24	33	20-58	19	11	5-42	60	18	14-37
YALE NEW HAVEN HOSP NEW HAVEN CT 06504	CT-41	4211	10	10-16	537	14	17-31	155	23	20-35	87	17	10-30	165	23	16-30	272	26	31-45	47	21	8-33	272	20	14-26

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST VINCENTS MED CTR BRIDGEPORT CT 06606	18	22	10-54	42	31	23-54	107	8	6-19	28	0	0-45	321	3	3-10	119	4	2-13	29	3	0-30	363	7	3-8	120	2	0-7
STAMFORD HOSPITAL STAMFORD CT 06902	9	0	5-61	13	31	20-70	35	9	3-24	40	3	0-37	175	5	2-10	75	3	1-14	17	0	0-96	135	4	2-10	82	0	0-9
THE CT HOSPICE INC BRANFORD CT 06405	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
THE HOSPITAL OF ST RAPHAEL NEW HAVEN CT 06511	50	20	12-44	38	29	27-61	135	7	5-17	36	0	0-44	441	5	3-8	181	7	3-13	25	0	0-25	705	5	3-7	171	1	0-6
VA HOSP WEST HAVEN CT 06516	6	0	0-70	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
WATERBURY HOSP WATERBURY CT 06720	16	44	11-58	18	28	14-57	86	12	4-18	23	0	0-68	243	2	3-10	91	2	2-14	13	0	0-100	158	4	3-10	202	1	0-5
WILLIAM W BACKUS HOSP NORWICH CT 06360	22	32	7-47	8	63	11-71	58	9	4-22	23	0	0-65	242	8	3-9	95	6	2-14	13	0	0-100	175	5	2-9	84	0	0-9
WINDHAM COMM MEM HOSP WILLIMANTIC CT 06226	10	10	9-65	10	20	15-71	39	0	3-24	3	0	0-100	102	7	2-12	38	0	0-20	8	0	0-100	90	7	2-12	87	1	0-9
WINSTED MEM HOSP WINSTED CT 06098	3	33	5-86	5	40	13-84	16	13	1-35	7	0	0-100	66	8	2-15	26	4	0-26	4	0	0-100	34	3	1-21	17	0	0-38
WW2 VETERANS MEM HOSP MERIDEN CT 06450	8	63	8-68	6	50	9-76	28	7	1-25	2	0	0-100	75	1	2-13	37	3	1-20	.	.		48	8	1-16	35	3	0-18
YALE NEW HAVEN HOSP NEW HAVEN CT 06504	43	14	6-38	27	48	21-59	118	7	5-17	82	0	0-11	353	4	2-8	181	3	2-12	43	0	0-56	521	6	3-8	138	1	0-6

*Written Comments Not Submitted.

BRIDGEPORT HOSPITAL

267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610
Telephone: 203 384-3464

Michael E. Schrader
President

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

We are in receipt of the HCFA Mortality Data and have the following comments and observations:

1. Bridgeport Hospital's Medicare Discharges for 1986 numbered 5682. The data analyzed by HCFA for the same period numbered 3565. It is difficult to come to conclusions on the reason for the discrepancy in the total number of Medicare patients.

2. Our records indicate that two patients listed as deaths after discharge actually died while in-patients; one case is not identifiable and believed to be, in fact, a duplicate of another case listed; and the dates of death are incorrect in six cases.

3. Of the HCFA sample of Bridgeport Hospital patients, 407 died within 30 days of admission. Of this number 70 died after discharge. In addition, it is not possible to verify the deaths of the 70 cases whose records showed them to be alive on discharge from the Hospital.

We concluded that the HCFA mortality rates, both those who died in the Hospital or presumed to have died after discharge, are well within the HCFA predicted ranges in all diagnostic categories. We have some concern about the use of principle diagnosis as indicator of the cause of death and the lack of information indicative of severity of illness. These data are vital in interpreting mortality data.

We appreciated having received this data from HCFA and have incorporated it into our very extensive quality assurance program. We hope that the inherent inadequacies of the data will be corrected so as to include in the formula the severity of illness of individual patients, a most important factor the review of the quality of care.

Sincerely,

Michael E. Schrader

MES:fgm

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

THE CHARLOTTE HUNGERFORD HOSPITAL
P. O. Box 988 Torrington, Connecticut 06790

October 26, 1987

Dr. William Roper
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

The Charlotte Hungerford Hospital wishes to thank the Health Care Financing Administration for the opportunity to comment on its 1987 report and for including our comments in the public distribution process.

A 188-bed acute care, voluntary, general hospital, The Charlotte Hungerford Hospital is the largest health care facility in Northwest Connecticut. In fact, 1987 saw us expand our facilities even further with the opening of a 58,000-square-foot Ambulatory and Critical Care Complex/Outpatient Services Center. As part of our providing health care for the approximately 84,000 persons in our primary and secondary service areas, we offer area-wide Radiation Therapy and Dialysis. Our host city, Torrington, has a large population of older people, so we are particularly concerned with that segment of the society and our services reflect that commitment.

As you are aware, our Hospital's Quality Assurance Program (QAP) has been in place for many years and provides for comprehensive review of all medical procedures with a watchful eye toward any unusual occurrences or incidents so that we may continually improve our service and promote the health and well-being of our patients at all ages. Mortality is, of course, one of many factors in that ongoing evaluation process. Our dedication to quality service for over 70 years has maintained The Charlotte Hungerford Hospital as a facility of professionalism, quality care, and compassion.

As for the data contained in your report, we would like to point out an inherent danger. To the laymen, our hospital would appear to fall well within the assigned parameters of mortality

data and based upon that data, the conclusion could be drawn that we offer quality care. While that is a valid conclusion and one we believe is shared throughout our service area, it comes from years of quality health care delivery by a dedicated staff of professionals and through our ongoing internal processes to evaluate and improve that care.

We feel strongly that a comparative statistical analysis of mortality data is not an accurate measure of quality care. The complexity of illness, diagnosis and treatment is such that only a fraction of the factors which affect mortality could be statistically represented. The patients' mental attitude, their general health prior to the onset of illness, the severity of illness at admission, the presence of multiple illnesses, and a host of other factors can play a pivotal role in the treatment and recuperation of each and every patient.

As your pre-report communication indicated, the report may provide helpful tools for finding answers but not the answers themselves.

Thank you for the opportunity to comment prior to the release of this report, and we hope our comments will help put the data in the appropriate perspective.

Regards,

Neal E. Yates
Director of Development
and Community Relations

Danbury Hospital
The Community Health Center
Danbury, CT 06810 Tel. 203-797-7966

William Allen Bauman, M. D.
Vice President
Medical Affairs

October 21, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

We appreciate the opportunity to respond to your request for comments concerning HCFA's plan to release selected mortality information for Medicare patients treated at Danbury Hospital during 1986.

We have verified that all except one of the deaths listed by HCFA occurred at Danbury Hospital or within 30 days of discharge. We reviewed deaths classified with principal diagnosis of cancer and would reclassify five (5) into a different principal diagnosis. The HCFA presentation is a useful check of our information systems and stimulates us to explore good measures of quality of care.

Mortality rates provide limited value as measures of quality. To the general public, "mortality rates" have a strong emotional conotation and despite explanations, people equate high mortality rates to poor quality. Rates do not adjust for factors that select patients for hospitals as a place to die. For example, sparcity of community based extended care beds, few hospice programs, religious, ethnic and economic considerations all encourage physicians to send sicker patients to hospitals and thus select for hospital admission, patients with high risk of dying. On the other hand, non quality issues such as availability of hospice, restrictive admission policies, agsence of certain hospital resources tend to keep sick patients out of the hospital and lead to lower hospital mortality rates. None of the variables relates to quality of care, but they do effect hospital and disease specific death rates.

We already have quality assurance mechanisms defined by the Joint Commission on Accreditation of Hospitals, hospital credentialling programs, committees of the hospital and medical staff, audits by the professional review organizations, and specialty societies. These and public and professional opinion help evaluate quality.

We would like to see hospital mortality rates adjusted for external factors. HCFA could develop "expected" rates that take into account variables that influence mortality. We are willing to participate in programs to improve methodologies that help hospitals compare quality of care and provide reassurance to the public and to the Health Care Financing Administration.

Sincerely yours,

William A. Bauman, M.D.

WAB:eh

cc: G. Robilotti, President, Danbury Hospital

DAY KIMBALL HOSPITAL

A Subsidiary of the Day Kimball Foundation

320 POMFRET STREET
P.O. Box 6001
PUTNAM, CONNECTICUT 06260-0901
203-928-6541/774-3366

CHARLES F. SCHNEIDER, FACHE
Executive Director

October 19, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper,

Day Kimball Hospital welcomes the input provided by the Health Care Financing Administration's data on mortality. Our Quality Assurance Committee, charged with monitoring the quality of care we deliver, is using this information in its ongoing work.

Although we were pleased to see that none of our mortality rates were above the expected range, we remain uncertain about some of the mathematics involved, especially in the area of differing ranges of expected mortality for different hospitals. We would appreciate more information regarding the methodology in future projects of this kind.

We also wish to reconfirm the American Hospital Association's position that although mortality is a useful tool to assist in the review of quality issues, it does not by itself identify the level of quality a hospital offers. Many other variables must be considered, including the availability of other health services along with characteristics of the patient population -- not just their health data, but socioeconomic status, educational attainment and other factors.

Again, thank you for the data and for the opportunity to comment.

Sincerely yours,

Charles F. Schneider

Charles F. Schneider, FACHE
Executive Director

rl/cfs/jvl

VHA. Member of Voluntary Hospitals of America, Inc.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

DAY KIMBALL HOSPITAL

320 POMFRET STREET
PUTNAM, CONNECTICUT 06260
203-928-6541

CHARLES F. SCHNEIDER, FACHA
Executive Director

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, MD 21207

RE: Hospital # 070003

Dear Sir:

In reviewing the statistics for mortality for our hospital I find that one death is recorded in error. I have attached the listing which was sent to us and have highlighted the case in question.

[redacted] was admitted to our hospital on July 20, 1986 and transferred to the University of Massachusetts Medical Center on July 25, 1986. He died at at the Medical Center on August 14. I believe that this case should not have been attributed to our statistics.

I have been in contact with the Medical Center and they confirm that the patient was admitted there on July 25, 1986 until August 14, 1986. I would appreciate your review of this information.

Sincerely yours,

Carol C. Harker

(Mrs.) Carol C. Harker, R.R.A.
Director, Medical Record Department

CCH/hs

ENC

cc: Charles Schneider
Executive Director

THE
GREENWICH HOSPITAL
ASSOCIATION

PERRYRIDGE ROAD
GREENWICH, CONNECTICUT 06830-4697 • TEL: 203 863-3000

EDWARD M. KENNEY
PRESIDENT

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

We are responding to your communication of September 21, 1987 which included specific data HCFA intends to release regarding Medicare patients who died in Greenwich Hospital, or died within 30 days of discharge. We agree with HCFA that mortality rates by themselves do not measure quality of care, and hope that every effort will be made by your organization to indicate this to the public. It is our belief that "quality" can only be evaluated through ongoing peer reviews and that your mortality data, which are just statistical comparisons, should only be used to identify or suggest areas of review.

Hospitals nationwide endorse HCFA's desire to "protect the Medicare patient from poor quality health care." Hospitals historically have been committed to providing patients with care appropriate to diagnosis. If the federal bureaucracy wishes to join us in this commitment, it will be evidence of a mutual concern. Indeed, the provision of quality health care has been and remains the goal of Greenwich Hospital. Our efforts are strictly monitored by a Trustee Quality Assurance Committee, and a Department of Quality Assurance that performs a 100% patient mortality review. Our accreditation by the Joint Commission on Accreditation of Healthcare Organizations, our cooperation with the state Peer Review Organization, and reviews performed by various colleges and other professional (both physician and non-physician) Associations clearly demonstrate the provision of quality health care.

In reviewing the data sent to us, we wish to identify specific limitations:

1. The extremely broad "ranges of predicted mortality rates" bring into question the usefulness of these categories. When death rates are applied to individual hospitals, they become less reliable because of the statistical effects of small numbers of cases. In our situation, the expected death rate in certain categories has a range of from 0% to 91%.

2. The number of deaths attributed to Greenwich Hospital includes patients (16%) who are no longer in-hospital. In some diagnostic categories, such as Pulmonary Disease, over 30% of the deaths were out of hospital. The assumption that the cause of dealth was the same as the cause of hospitalization is highly questionable and difficult to prove.

3. In our data, 11 of the 16 categories had less than 100 cases, and five of the categories had less than 50 total cases. Percentages based on these small samples have relatively little significance.

4. HCFA's method for calculating this data is not reproducible by individual hospitals or groups of hospitals. Therefore, true verification is not possible.

In summary, we believe that decisions relative to the quality of care rendered at a hospital cannot be made on the basis of the mortality data that HCFA has compiled, and that the release of this data will have the effect of unnecessarily undermining the confidence of communities in their hospitals. This most certainly is a disservice to the people we both serve.

Sincerely,

Edward M. Kenney
President

EMK:rh

cc: John Lynch - CHA

THE GRIFFIN HOSPITAL

Hospital = 070031

Griffin Hospital's Medicare mortality experience for 1986 for all causes as well as for specific diagnostic categories fell within the HCFA range of predicted mortality rates. None of the ranges were exceeded. In the category "All Causes", the rate was 13%. Twenty-two percent of the hospitals in Connecticut had this rate or higher.

Medicare patients admitted to Griffin have been staying approximately 10.5 days. In 1984, the stay was 10.5 days, in 1985 10.3 days, in 1986 10.7 days and in 1987 10.2 days. The 1986 stay of 10.7 days was the highest length-of-stay in four years and was not repeated in 1987.

On average, all types of patients admitted to Griffin are staying about 7.5 days. The four-year trend is: 1984 7.6, 1985 7.2, 1986 7.5, and 1987 7.0 days.

Griffin's mortality rate for patients over age 65 who undergo surgery has been 6.5, 6.7, and 6.3 from 1984 - 1986. There has been a further decrease in 1987 to a rate of 4.6.

In 1986, the rate of people admitted to the hospital and acquiring an infection while here increased to 4.1 from 3.8 in 1985. However, in 1987 efforts to decrease this nosocomial infection rate resulted in a rate of 3.9.

When comparing Griffin's mortality experience to the Northeast Region using a nationwide database from Commission on Professional and Hospital Activities, (CPHA), Griffin's experience was lower than the region. The regional rate for 1986 was 1.125. Griffin's rate was .930. The region's rate for those age 65-74 was 1.110 versus Griffin's .907. For those age 75 or more, the region rate was 1.133. Griffin's was .983. The Northeast region includes the states of Pennsylvania, New York, New Jersey, Connecticut, Rhode Island, Massachusetts, Vermont, New Hampshire and Maine. (A rating of 1.00 is the expected mortality rate).

An indication of intensity level is the Resource Need Index, (RNI). This is defined by CPHA as measuring "...the expected effect of case mix on the resources needed to treat patients. An RNI of 1.00 indicates a case mix of average complexity. An RNI

greater than 1.00 indicates higher than average case mix complexity." In 1986, Griffin had its highest RNI in four years. From 1984 - 1987, the RNI has been 1.22, 1.25, 1.26, and 1.21, respectively.

These indicators demonstrate that in 1986 Griffin treated patients who were medically more complex than average and that those patients over 65 years of age stayed longer than earlier years (10.7 days on average). Preliminary data for 1987 indicate improvement in mortality and infection indicators. Griffin's mortality experience in 1986 was within HCFA's predicted ranges and below the Northeast region's rate.

Over the past several years, Griffin has continually improved its quality review process conducted by its medical staff. One hundred percent of all patients are reviewed against quality screens developed by the medical staff. Those cases not meeting the screens are referred to the appropriate clinical specialty for individual case review. Additionally, all instances of death are examined by members of the medical staff and reports of quality assurance activities are submitted to the Medical Executive Committee and the Board of Trustees.

Hartford Hospital

October 23, 1987

William L. Roper, M.D.
Administrator, Health Care Financing Administration
Department of Health and Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC

Dear Dr. Roper:

We at Hartford (CT) Hospital commend the Health Care Financing Administration (HCFA) for its continued efforts at reviewing quality of care.

There are many components to the measuring of quality of medical care of which mortality is but one. Internal evaluation of the quality of care at Hartford Hospital involves the monitoring of many different indicators, some of which have a more direct relationship to quality of care than mortality rates. In reviewing our own ongoing data and combining these data with HCFA's, we are pleased to find no indication of substandard quality of care at Hartford Hospital by any of these methods.

We agree with HCFA's statement that mortality figures are an imperfect means of judging the quality of a hospital or for comparing one hospital with another.

Attached is a list of 25 deceased patients whose date of admission, discharge or death was incorrectly reported by HCFA. In some cases, the hospital admission reported was not the final admission for that patient. In other cases, expiration dates are in error. Finally, some patients' discharge dates are incorrect. In providing this information, we respectfully request that HCFA correct its data surrounding these 25 patients.

In closing, please accept our sincere gratitude for providing us with the opportunity to review these data prior to public release.

Sincerely,

John Meehan

John J. Meehan
President and
Chief Operating Officer

HARTFORD, CONNECTICUT 06115-0729 • TELEPHONE: (203) 524-3011

Hartford Hospital

HIC #	Age/Sex	Date of Admission	Date of Discharge	Date of Death	Comments
1) [redacted]	75m	10/05/86	*10/05/86	10/06/86	Patient was not discharged on 10/05/86. Remained hospitalized and expired on 10/06/86.
2) [redacted]	74m	10/20/86	11/13/86	*11/14/86	Patient expired on 11/13/86 while inpatient.
3) [redacted]	88f	09/10/86	10/07/86	*10/08/86	Patient expired on 10/07/86 while inpatient.
4) [redacted]	96m	09/18/86	10/0I/86	*10/02/86	Patient expired on 10/01/86 while still inpatient.
5) [redacted]	76m	09/25/86	*10/05/86	10/06/86	Patient was not discharged on 10/05/86 and was still hospitalized at the time of expiration on 10/06/86.
6) [redacted]	67m	12/09/86	12/30/86	*12/31/86	Patient expired on 12/30/86 while still hospitalized.
7) [redacted]	75f	03/16/86	03/22/86	*03/23/86	Patient expired on 3/22/86 while still hospitalized.
8) [redacted]	71m	06/23/86	07/04/86	*07/05/86	Patient expired on 7/04/86 while still hospitalized.

*Incorrect

CT 13.1

	HIC #	Age/Sex	Date of Admission	Date of Discharge	Date of Death	Comments
9)	[redacted]	76m	01/03/86	01/19/86	*01/23/86	Patient expired on 01/19/86 while still hospitalized.
10)	[redacted]	77m	04/08/86	04/09/86	*04/14/86	Patient expired on 04/09/86 while still hospitalized.
11)	[redacted]	70m	05/19/86	05/25/86	*05/31/86	Patient expired 05/25/86 while still hospitalized.
12)	[redacted]	82m	01/29/86	02/22/86	*02/28/86	Patient expired 02/22/86 while still hospitalized.
13)	[redacted]	67f	05/15/86	05/21/86	*05/31/86	Patient expired on 05/21/86 while still hospitalized.
14)	[redacted]	75m	*07/07/86	*07/14/86	07/24/86	Second to the last admission identified in this data. Patient readmitted 07/24/86 and expired in hospital on 07/24/86.
15)	[redacted]	92f	*10/12/86	*10/21/86	11/02/86	Patient was discharged on 10/21/86; however, was readmitted 11/02/86 and expired on that inpatient day.
16)	[redacted]	69m	08/10/86	*08/10/86	08/22/86	Patient was transferred to another acute care facility and needs to be counted in the receiving hospital statistics.

*Incorrect

CT 13.2

	HIC #	Age/Sex	Date of Admission	Date of Discharge	Date of Death	Comments
17)	[redacted]	76m	*12/21/86	*12/27/86	01/10/87	Second to the last admission identified in this data. Patient readmitted 12/27/86 and expired 01/10/87 while hospitalized.
18)	[redacted]	75f	*08/17/86	*08/21/86	09/04/86	Patient readmitted to the hospital on 09/04/86 and expired as an inpatient.
19)	[redacted]	74m	*03/06/86	*03/11/86	03/28/86	Patient readmitted on 03/15/86 and expired on 03/28/86 while still in hospital.
20)	[redacted]	61m	*02/18/86	*02/28/86	03/19/86	Patient readmitted on 03/18/86 and expired while inpatient 03/19/86.
21)	[redacted]	91m	*01/26/86	*01/31/86	*02/21/86	Patient readmitted on 02/09/86 and expired while in the hospital on 02/22/86.
22)	[redacted]	62m	04/04/86	04/07/86	*04/30/86	Patient expired while in the hospital on 04/07/86.
23)	[redacted]	78m	*12/18/86	*12/23/86	01/17/87	Patient readmitted on 12/26/86 and expired on 01/17/87 while an inpatient.
24)	[redacted]	69m	12/03/86	12/05/86	*12/31/86	Patient #706-03-9511A expired on 12/05/86 while still an inpatient.

CT 13.3

*Incorrect

	HIC #	Age/Sex	Date of Admission	Date of Discharge	Date of Death	Comments
25)	[redacted]	97m	10/19/86	10/22/86	*10/21/86	Patient expired in the hospital on 10/22/86.

CT 13.4

*Incorrect

THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

JOHN DEMPSEY HOSPITAL
Farmington, Connecticut 06032
Medicare Provider #: 07-0036

October 22, 1987

William L. Roper, M.D
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

I am writing to comment on the hospital-specific mortality rates distributed to the John Dempsey Hospital last month.

As a former director of the PSRO program, I would like to congratulate you on taking a major step forward in providing quality of care data to consumers as well as to the hospital industry. Many of the most serious problems in your first distribution of mortality rates have been corrected. Your staff have done an outstanding job in improving the methodology used in making cross-hospital comparisons.

We have a few corrections to make in the data for our hospital. All of these are presented as Attachment A. These include nine patients who died in the hospital rather than after discharge and one case where our records do not show the admission.

The most serious general concern that I have with the data is in its basic accuracy. I do not understand why date of death should be such a major source of error but suspect that there may be problems with the incorporation of SSA files. We also noted multiple instances in which the age was incorrect. Since age is an important adjustor, a pattern of errors in this field may alter some of your final observations. Because our hospital is relatively small, I also have concerns that some cells contain too few observations to have meaning.

An Equal Opportunity Employer

In view of the extraordinary difficulties inherent in grouping all discharges in a manner which produces comparable death rates, I think that the categories used are a reasonable and sensible compromise.

In future, I would suggest that you give some thought to clustering some subset of all discharges into "marker" groups: clean categories in which similar competence in treatment can be expected to produce similar death rates. These marker groups could either be highlighted as the most reliable aspect of the analysis or used as the basis for the entire analysis. There is no reason that I can see to insist that death rate analysis be exhaustive. The use of marker groups would avoid the possibility, which is inherent in the current method, that referral patterns for diseases such as cancer will create falsely high or falsely low rates for individual hospitals. A better grouping method would, in my opinion, be far preferable to any attempts to adjust for facility characteristics.

Thank you for the opportunity to provide our comments before publication of this important information.

Sincerely yours,

Helen L. Smits, M.D., F.A.C.P.
Director
John Dempsey Hospital

HLS:cao
(HCFA1020)

cc: Dr. James Mulvihill
Vice President for Health Affairs

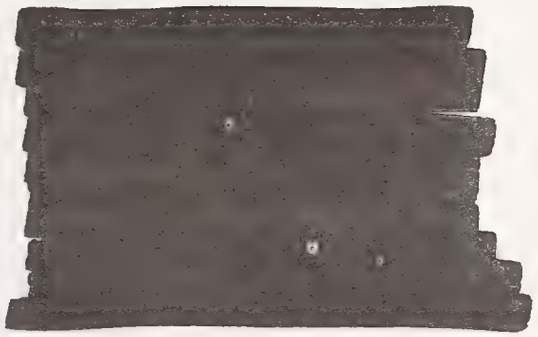
Attachment A

Corrections to the HCFA Mortality Data	HCFA	John Dempsey Hospital
1. Total Medicare Mortality cases for 1986 occurring within 30 days since last hospital admission	92	91
Explanation: One (1) patient where there is no record of admission.		
2. Total deaths during hospitalization	66	74
Explanation: a) Nine (9) corrections to HCFA data identified where patients died in hospital rather than after discharge.		
b) One (1) correction to HCFA data identified where we have no record of the admission.		
3. Total deaths post hospitalization	26	17
Explanation: Same as above explanation (Number 2)		

Note: Attached is a required revision list to the HCFA mortality statistics indicating corrections.

CORRECTIONS TO HCFA PATIENT EXPIRATION DATES

CT 14.3

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LTRS)	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	CORRECT DATE OF DEATH
		CA	085	M	02/26/86	02/26/86	02/27/86	02/26/86
		CA	068	F	11/01/86	11/02/86	11/30/86	11/02/86
		HM	084	F	03/12/86	03/18/86 *	04/08/86	
		ME	085	F	03/17/86	03/25/86	03/31/86	03/25/86
		PN	083	F	06/02/86	06/18/86	06/30/86	06/18/86
		PN	085	F	12/17/86	12/26/86	12/31/86	12/26/86
		PN	075	F	02/19/86	02/25/86	02/28/86	02/25/86
		UN	076	F	12/01/86	12/13/86	12/31/86	12/13/86
		UN	088	F	02/23/86	02/23/86	02/28/86	02/23/86
		UN	085	M	11/07/86	11/12/86	11/14/86	11/12/86

* - DENOTES UNVERIFIED ADMISSION

Lawrence and Memorial Hospital

NEW LONDON, CONNECTICUT 06320 • (203) 442-0711

JOHN F. MIRABITO, President

October 16, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D. C. 20201

Dear Dr. Roper:

We are in receipt of the 1986 mortality information for Medicare patients and thank you for providing this to us well in advance of its public release. We have now had an opportunity to review the data and, while we are not totally familiar with the methodology used to determine the predicted mortality rates or actual mortality rates, the review has been most helpful to us in our quality assurance program.

Very truly yours,

John F. Mirabito
President

JFM:cb

MIDDLESEX MEMORIAL HOSPITAL
28 CRESCENT STREET MIDDLETOWN, CT 06457 (203) 347-9471

COMMENTS ON HCFA MORTALITY DATA

Middlesex Memorial Hospital, Middletown, CT

DATA VERIFICATION

The data used by HCFA for calculating 1986 mortality rates for MMH was based on 2864 Medicare patient discharges in 1986. Of these, HCFA data indicates that 301 died while still patients at MMH, and 101 died after discharge. Hospital records indicate that 4224 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of some Medicare patients to MMH during 1986. We have no way to verify whether HCFA's 2864 total, which is the basis for the denominators used to calculate our mortality rates, is correct. It is also impossible for us to verify whether all of the 101 patients listed as dying after discharge actually died within 30 days of admission. Information concerning death after discharge is not included in the patient's medical record.

Our records indicate that of the 301 Medicare patients who died while still an inpatient, two (2) were still alive at the time of discharge. Other discrepancies noted in our comparison of HCFA and MMH data include:

1. MMH data indicates that seven (7) additional patients' dates of death coincided with their date of discharge.

2. There is a discrepancy in the principal diagnosis of thirteen (13) patients, and

3. There is a discrepancy in the ages for nine (9) patients. A detailed list of the discrepancies is attached.

A detailed listing of these discrepancies is provided in Attachment 1.

REMARKS

MMH was within the predicted mortality range for each of the 16 diagnostic categories and the "All Causes" category. We would, however, like to comment on the fact that MMH has a fully dedicated Hospice Unit for the care of terminally ill patients. While the HCFA mortality data is adjusted for such variables as patient age and sex, the number of previous admissions and certain comorbid conditions, these adjustments are not designed to measure the severity or stage of the illness which resulted in the patient's death. The more severe a patient's illness or the further his/her

disease has progressed at the time of admission, the more likely he/she is to die within 30 days of the admission. Since hospice units specialize in the care of terminally ill patients, these patients have a high probability of dying within 30 days of admission.

In cross-referencing our list of Hospice Unit patients with HCFA's list of patients who died within 30 days of admission, we determined that 70 of the 402 HCFA mortalities (17.4%) were Hospice patients. In addition to these 70 patients, there are, of course, additional patients among the 402 mortalities whose prognosis on admission was such that their demise was anticipated. However, the existance of the Hospice Unit resulted in a substantially more complex Medicare patient case mix due to the advanced stage and severity of illness for Hospice patients. This more complex case mix, in all probability, resulted in MMH having a higher overall mortality rate and higher rates in certain of the diagnostic categories. Thus, even though MMH's rates were within the predicated ranges, we feel they would have been even lower for certain categories had we not had a hospice unit.

MR/2093E
10/27/87

MIDDLESEX MEMORIAL HOSPITAL
Middletown, Connecticut

ATTACHMENT 1

DATA DISCREPANCIES

1. Date of Death

ID#	NAME	HCFA DATE	MMH Date
[redacted]		3/20/86	Unknown
		5/27/86	Unknown
		9/18/86	9/17/86
		10/14/86	10/13/86
		6/28/86	6/27/86
		2/16/86	2/15/86
		2/14/86	2/13/86
		2/10/86	2/9/86
		8/29/86	8/28/86

2. Age

ID#	NAME	HCFA AGE	MMH Age
[redacted]		82	79
		83	89
		98	97
		92	93
		93	88
		91	97
		80	70

3. Principal Diagnosis

ID#	NAME	HCFA CODE	MMH CODE
[redacted]		197.6	584.9
		162.8	428.0
		197.7	276.5
		599.0	584.9
		427.89	431.0
		410.9	411.1
		410.9	458.9
		276.5	150.9
		486.0	795.59
		482.1	038.40
		477.0	577.0
		799.1	805.4
		799.1	507.0

MR/alg
2476U

mount sinai hospital

Office of the President

October 27, 1987

William L. Roper, M.D.
Adminstrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Mount Sinai Hospital appreciates the opportunity to review and comment on the mortality data prior to its general release by HCFA. This letter describes the review process undertaken at Mount Sinai Hospital to date and our future plans for use of the data.

The Administration and Medical Staff at Mount Sinai Hospital concur with the view stated in your letter of September 21, 1987 that mortality statistics alone do not provide "a complete measure of the quality of care of an individual hospital." Rather, the data are seen as one useful source of information to focus the peer review and quality assurance process already in place at Mount Sinai Hospital.

Mount Sinai Hospital has a formal Quality Assurance (QA) program which is authorized by the Board of Trustees and is administered by the Quality Assurance Coordinating Council. The purpose of the QA program is to assess objectively and systematically the quality of care provided within the Hospital. The QA Coordinating Council oversees an ongoing monitoring process of patient care review by identification, evaluation and follow-up. The HCFA mortality data have been submitted to this committee for review.

The information supplied by HCFA was first reviewed for accuracy. We found the data to be generally accurate with only occasional and minor discrepancies, usually with regard to patient age.

The data show Mount Sinai mortality rates to be well within the predicted ranges developed by HCFA for all 16 diagnostic categories. In one category, Severe Acute Heart Disease, the mortality rate, while within the predicted range, is at the upper end of the range. Therefore it was determined that a focused review of the 30 cases within this category would be of benefit to the quality assurance process.

500 Blue Hills Avenue / Hartford, Connecticut 06112 / (203) 242-4431

The 30 medical records of the cases in the Severe Acute Heart Disease category were reviewed by the Director, Quality Assessment and the following items were examined:

- Length of stay in the Hospital, in the Emergency Department and by each Hospital unit or floor,
- Source and type of admission,
- Attending and consulting physicians,
- Prognosis on admission,
- Whether, and where a cardiac arrest occurred,
- Whether a "DNR", (Do Not Resuscitate) order was written,
- Where the patient died,
- Principal and secondary diagnoses,
- Cause of death.

The Director of Quality Assessment, in conjunction with a physician, a practicing cardiologist, then focused the review on determining whether the assessment and management of the patients was appropriate.

The results of this process revealed no quality of care problems. This group of 30 patients was found to be severely ill and quite elderly. Among these patients, 56.7 percent had a principal diagnosis of acute myocardial infarction; 30 percent had a diagnosis of myocardial infarction. The remaining 13.3 percent had principal diagnoses of: cardiac arrest; ventricular fibrillation or subendocardial infarction.

Significant comorbidities were present in all patients. Among these were: congestive heart failure, diabetes, hypertension, cancer, previous stroke, previous myocardial infarction, cardiogenic shock, cardiomyopathy, renal failure and respiratory failure.

Other findings included the following:

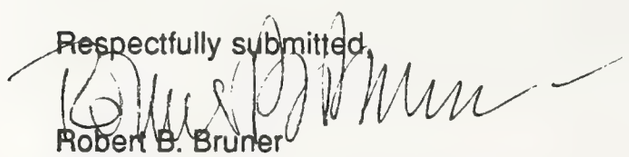
- The average age of these patients was 77.1 years, with 18 (60 percent) being 75 years or older, and 7 (23.3 percent) being 85 years and older. One patient was 100 years old.
- All 30 (100 percent), were admitted on an emergency basis, as opposed to elective or urgent. Ten patients (33.3 percent) were transferred to Mount Sinai Hospital from a nursing home.
- Twenty-four patients (80 percent) were admitted to the Emergency Department with a prognosis of critical, poor or guarded, with the large majority falling into the first two categories.
- Twenty-two patients (73.3 percent) suffered a cardiac arrest either directly prior to their admission or following their admission.

- Twenty-four patients (80 percent), were treated in Mount Sinai Hospital's Coronary Care Unit, (CCU) where intensive medical and nursing coverage, as well as state-of-the-art monitoring equipment is readily available. Seventy percent of the patients died in the CCU.
- The large majority (76.7 percent) received cardiology consults. Those who did not were either DNR patients, for whom active interventionist care was not desired by the patient or the family, or were patients who were in the Hospital for only a few hours.
- A large number of patients did receive aggressive medical treatment where indicated, including: arterial monitoring (30 percent); temporary pacemakers, (23.3 percent); intubation or ventilation (33.3 percent).
- Thirteen patients (43.3 percent) had DNR, (Do Not Resuscitate) orders.

In summary, the patients in this category were severely ill, with a poor prognosis on admission. They were treated in the appropriate settings by the appropriate professionals and received high quality patient care.

The results of this study will be presented to the Quality Assurance Coordinating Council at its next scheduled meeting for review and follow-up action if deemed necessary by the committee.

Respectfully submitted,



Robert B. Bruner
President and Executive Director

New Britain General

New Britain
General Hospital

100 Grand Street
New Britain
Connecticut 06050
203/224-5011

Laurence A. Tanner
President

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

New Britain General Hospital intends the following material to be in response to data contained in the category designated "Metabolic Electrolyte Disorders, DRG #296. We are attaching the itemization of the HCFA mortality data for NBGH.

Upon review of the data in this category, we discovered an error had been made in sequencing one case. This error was discussed with the Connecticut Peer Review Organization (C.P.R.O.), the federally approved review organization, which has agreed to the necessary correction. The correct DRG should be 449, Adverse Effect of a Drug.

In a telephone conversation with H. Young of HCFA on October 23, 1987, we were informed that it was unlikely that the necessary adjustments to the computer data would be made in time to avoid incorrect data being released. Therefore, we are offering this as evidence that in this instance the released material would be incorrect, unless the above change was actually made.

Sincerely yours,

Laurence A. Tanner
President

Attachment

cc: Mrs. Marcia Petrillo, Executive Director
Connecticut Peer Review Organization

NEW MILFORD HOSPITAL

October . , 1987

William Roper, M.D., Administrator
Department of Health and Human Resources
H.C.F.A. Room 314 - G
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Dr. Roper:

A preliminary review has been made of the HCFA mortality statistics concerning Medicare patients treated at New Milford Hospital in 1986. We reviewed deaths during and post hospitalization, coding of diagnosis and, verification of dates of admission/discharge.

Data Verification

The data used by HCFA indicates that a total of 76 Medicare patients admitted to New Milford Hospital died within 30 days of admission. Of these, 40 died while still a patient of the hospital, while 36 died after discharge. Our own records indicate that 1,454 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at New Milford Hospital is correct. New Milford Hospital records indicate that one of the 76 was transferred to an acute care hospital in Connecticut, thereby decreasing New Milford Hospital statistics to 75. Our own records also indicate that of the 75 Medicare patients who died within 30 days of admission while still an inpatient, 22 were still alive at the time of discharge. It is impossible to determine the percentage of the 22 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

New Milford Hospital's actual mortality rate does not fall outside of the range of the predicted mortality rates in any of the diagnostic categories.

There is a variance between HCFA data on in-hospital/post hospital deaths and New Milford Hospital's data. HCFA listed some patients as having died post hospital, when actually the patients had been readmitted to New Milford Hospital and expired in hospital. Please see Attachment 1 for the numbers. Attachment 2 gives the corrected data for each patient.

In summary, as a small, active hospital we believe that the statistics indicate a low mortality rate. The diagnosis indicating a higher post hospital death rate (Other Diagnosis and Pulmonary Disease) had commorbidity of Cancer and therefore post hospital death would be expected. Per hospital procedure we will continue to review all mortality cases and will review in detail all of the cases noted in the HCFA study.

Sincerely,

Richard E. Pugh
President

REP:ck
Attachments

ATTACHMENT 1

New Milford Hospital - ID # 070015

Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	5	8	8	4
CE -- Cerebrovascular Accidents	4	2	5	1
GC -- Gastrointestinal Catastrophes	1	1	1	1
GI -- Gastrointestinal Disease	0	1	0	1
GU -- Urologic Disease	0	1	0	1
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	4	1	5	0
HM -- Severe Chronic Heart Disease	5	3	7	1
HS -- Severe Acute Heart Disease	3	0	3	0
ME -- Metabolic/Electrolyte Disturbances	1	2	1	2
OP -- Orthopedic Disorders	0	0	0	0
PN -- Pulmonary Disease	5	11	9	7
RN -- Renal Disease	1	0	1	0
SE -- Sepsis	0	0	0	0
TR -- Severe Trauma	0	2	1	1
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	10	5	10	5
Total -- All Categories	40	36	53	22

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

Attachment 2

NEW MILFORD HOSPITAL - ID # 070015

Patient ID # (HIC)	Diagnosis Category	Corrected Information
[redacted]	PN	Died 2/12/86 in hospital.
[redacted]	TR	HCFA's date of death incorrect; it was not after discharge. Patient readmitted 3/19/86 and died 3/27/86.
[redacted]	CA	Patient readmitted on 3/24/86 and died in hospital on 3/29/87.
[redacted]	PN	Patient readmitted on 3/13/86 and died in hospital on 3/20/87.
[redacted]	PN	HCFA has incorrect date of death. She died in hospital on 3/28/86.
[redacted]	GU	Patient was readmitted on 4/18/86 and died in hospital on 4/29/86.
[redacted]	UN	Patient died in hospital on 4/22/86.
[redacted]	HL	Patient was readmitted on 5/8/86 and died in hospital on 5/24/86.
[redacted]	HM	Patient was readmitted on 7/3/86 and died in hospital on 7/6/86.
[redacted]	PN	Patient was readmitted on 7/7/86 and died in the hospital on 7/8/86.
[redacted]	PN	The admit date is 9/17/86 and not 9/16/86.
[redacted]	CA	Patient was readmitted on 10/27/86 and died in the hospital on 10/28/86.
[redacted]	CE	Admit date is 12/29/86 and not 12/28/86.
[redacted]	CA	Patient was transferred to another acute care hospital (Danbury Hospital) on 10/13/86.

Patrick Neligan, M.D.
Vice President of Medical Affairs/
Medical Director

Norwalk Hospital

Norwalk,
Connecticut 06856

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Medicare Provider Number 070034

Dear Dr. Roper:

SUBJECT: HCFA Mortality Data

We welcome this opportunity to comment on the package of data concerning Medicare Mortality Rates in Norwalk Hospital during 1986. High quality care is the first priority of the Board of Trustees, Hospital Management, and the Medical Staff of this institution. Quality care is continuously being evalutated through the Patient Care Evaluation Committees, the Medical Audit Committee, the Joint Conference Committee, the Quality Assurance programs, and Peer Review. We cannot accept that mortality rates by themselves measure the quality of patient care. Mortality rates that are higher or lower than predicted serve to indicate a potential problem of quality care at Norwalk Hospital leading to a prompt investigation to determine whether, in fact, a problem does exist and if swift corrective action is indicated.

The data supplied do not include a determination of severity or acuity of illness at the time of hospital admission, whether or not the patient was transferred to the hospital from an Extended Care Facility, whether the patient had a terminal or irreversible illness or whether the patient was being treated at home prior to hospitalization or the patient's general physical health and mental status.

A review of three of the deaths occuring within 30 days of discharge from Norwalk Hospital indicates that the causes of all three deaths was totally

unrelated to the reason for their previous hospitalization and primary diagnosis. It does not appear fair or equitable that a death occurring following hospitalization but due to a cause unrelated to the hospitalization, reflect adversely on the mortality rate of a specific diagnostic category for which the patient was hospitalized. The death of a patient fourteen days following her return to an Extended Care Facility after a three days period of hospitalization at Norwalk Hospital and of a cause totally unreleated to the reasons for her hospitalization placed the Mortality Rate for "Gynecology low risk" at 8% as compared to Connecticut hospital statewide average rate of 0.42%. If this death was not reflected in your statistical mortality data, the mortality rate of Norwalk Hospital for this specific diagnostic category would be 00.00%.

A review of the mortality rates in other diagnostic categories at Norwalk Hospital, particularly "Gastrointestinal Catastrophies High Risk", "Stroke High Risk", and "Orthopaedic Conditions Low Risk", indicates that in a large number of cases, the wishes and desires of the patient and his or her family not to prolong life and postpone death by demanding the cessation of aggressive medical treatment has resulted in in-hospital deaths. These deaths have impacted on hospital mortality rates.

Death can be an adverse outcome of hospital care, a natural occurrence or a patient or family dictated event. In instances where the quality of life following sickness will be unacceptable to the patient and his or her family, the choice of death is the alternative with a resulting higher in-hospital mortality rate. Many patients and family members chose death rather than a vegetative state, a life of intractable pain, incapacity and suffering for them and their loved ones.

We appreciate the opportunity to respond to Health Care Financing Administration in the matter of Mortality Data as they refer to Norwalk Hospital.

With assurance of our continuing commitment to high quality health care, I am,

Very truly yours,

Patrick Neligan M.D.

Patrick Neligan, M.D.
Vice President of Medical Affairs/
Medical Director

PN:ctb

The Park City Hospital

695 Park Avenue
Bridgeport, Connecticut 06604
(203) 579-5000

October 27, 1987

Dr. William Roper
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for sending us mortality information for Medicare patients treated in Park City Hospital.

While we have been able to verify the accuracy of most of the data, we have also found some inconsistencies. Of the eleven patients listed as having died post discharge, our records indicate that four of them died in the hospital. They are the following individuals:

MEDICARE	SURNAME	DIAGNOSTIC CATEGORY	ADMISSION	DISCHARGE	DEATH
[redacted]		CE	02/05/86	02/27/86	02/28/86
[redacted] died at Park City Hospital on 02/27/86)					
[redacted]		HM	12/15/86	12/27/86	12/31/86
[redacted] died at Park City Hospital on 12/27/86)					
[redacted]		PN	02/11/86	02/23/86	02/28/86
[redacted] died at Park City Hospital on 02/23/86)					
[redacted]		UN	03/10/86	03/21/86	03/29/86
[redacted] was discharged on 3/21/86, re-admitted on 03/29/86 and died on 03/30/86)					

Please make these corrections on your Park City Hospital data protocols and thank you again for sending us mortality data specific to our hospital. I know it will be very helpful to all of us.

Sincerely,

Bruce J. Markowitz
President and Chief Executive Officer

BJM:eah
VIA FEDERAL EXPRESS

SAINT
FRANCIS HOSPITAL
AND MEDICAL CENTER

114 WOODLAND STREET · HARTFORD, CONNECTICUT 06105-1299 · TEL. (203) 548-4000

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Re: Medicare Provider Number: 070002

Dear Doctor Roper:

We have received the mortality information which you sent us on September 21, 1987.

Please be advised that the following two cases cannot be identified by us as treated at Saint Francis Hospital and Medical Center:



Our review of the mortality information is ongoing. We are mindful of your comments in your September 21 letter that "until we have developed additional statistical measures to deal with complex issues such as severity of illness, we can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals."

Sincerely yours,

Mary Ellen Doyle

Mary Ellen Doyle
Vice President

MED/cg
c: Sister Francis Marie

St. Joseph
Medical Center

Office of the President

128 Strawberry Hill Avenue
P.O. Box 1222, Stamford, CT 06904
(203) 353-2001

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department Health & Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Roper:

Thank you for forwarding to St. Joseph Medical Center the Health Care Financing Administration mortality information for calendar year 1986. This data is currently being analyzed as part of the St. Joseph Medical Center Quality Assurance review process.

All inpatient deaths are evaluated by Quality Assurance committees composed of physicians and other health care professionals. Careful study is given to each case regarding the appropriateness of care and the safety of the environment.

The Health Care Financing Administration data differs from the information routinely referenced by hospitals insofar as deaths occurring after discharge may not be known to the hospital. Upon receipt of this information, we are providing an additional review role in order to ascertain if the patient and family were prepared for the options available within our community.

Connecticut Acute Care Facilities reflect a very high quality of health care. Quality Assurance programs within the institutions have been in the forefront nationally. The Connecticut Peer Review Organization, Inc. has also joined with the hospitals to promote the philosophy of providing optimum patient care.

As a member of the American Hospital Association, St. Joseph Medical Center endorses the analysis prepared by Carol M. McCarthy, Ph.D., J.D. in which it was stated that this information represents a measurement of "the relationship between a limited set of patient characteristics and the risk of death. With regard to hospital performance, it is no more than a screening tool for use in clinical and management review".

Sincerely yours,

Sister Daniel Marie

Sister Daniel Marie
President/CEO

SDM/cwb

St. Mary's
A HEALTH CARING CENTER
56 Franklin Street
Waterbury, Connecticut 06702

Office of the Executive Director
(203) 574-6300

October 26, 1987

William M. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the H.C.F.A. mortality data which was forwarded to St. Mary's Hospital.

The data utilized by H.C.F.A. indicate that a total of 406 Medicare patients admitted to the hospital during 1986 died within 30 days of admission. Of these, 292 died while still a patient of the hospital, while 114 died after discharge.

The H.C.F.A. data indicate a total of 3,135 Medicare admissions during 1986; our records reflect a higher number of Medicare admissions for the year. Presumably, the discrepancy reflects the exclusion of multiple admissions of individual beneficiaries to different hospitals in 1986.

After reviewing the data, we believe there are major limitations to the methodology utilized by H.C.F.A. in the study. These limitations are outlined as follows:

1. We are unable to verify the deaths post-discharge. Deaths may be attributed to the hospital which were unrelated to the condition of the patient under treatment at the time of discharge or that resulted from management of the patient at home or in a post acute care facility.

2. The methodology does not account for variations in patients' severity of illness and socioeconomic factors. Hospitals which serve more seriously ill patients or a higher proportion of medically indigent patients such as St. Mary's, would expect a higher mortality rate. Thus the model does not accurately predict hospital mortality rates as it does not consider the patient's general health status, state of illness, psychological condition and family support.

3. Without detailed information concerning the billing data available to H.C.F.A. in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnosis or other data used in the H.C.F.A. analysis.

4. The model has not been validated. That is to say, the ability of it to detect differences in quality has not been evaluated. It presumes that each hospital's patients are "average" except with relation to the few characteristics included in the model.

5. The data is not all-inclusive as it applies only to Medicare patients who died in 1986 and differs from other indicators of in-patient mortality.

6. The cause of death is based on the principle diagnosis of the patients which are not necessarily the cause of the deaths. Patients may have multiple medical problems and/or multiple episodes of illness during one stay, or a terminal disease underlying the most current acute episode of illness.

7. Lastly, and most importantly, death is not a measure of quality patient care. Conclusions about deficiencies in care must never be made solely on outcome measures because poor outcomes can result when no deficiencies are identified in complying with accepted standards of care. Death is one of them, and not necessarily a poor outcome. Quality can only be evaluated through the process of peer review and quality assessment activities and not through simple statistical comparisons.

Quality of care is of utmost importance to the St. Mary's Hospital Board, Management and Medical Staff. St. Mary's is proud of its on-going peer review and quality assurance activities. Each Medical and Surgical Division conducts monthly peer review sessions which address issues surrounding quality of patient care--including the review of deaths and complications.

In only one of the diagnostic categories identified by the H.C.F.A. study, did the hospital's actual mortality rate fall outside of the range of the predicted mortality rate based on St. Mary's Hospital's case mix. Each of the cases within the category of metabolic electrolyte disturbance was reviewed by the appropriate Department Chief and Section Chief, individually and jointly. It should be pointed out that the average age of the patients who fell within this diagnostic category was 79.

In addition, although only one diagnostic category reflected a mortality rate outside the range of the predicted mortality rate based on our case mix, the hospital's Department and Section Chiefs conducted an intensive review of many of the diagnostic categories.

In general, of those patients who died in the hospital, most were at an advanced age and had severe associated disabilities. In all cases, the quality of care rendered to the patient was deemed appropriate by the physicians.

It is pleasing to note that despite a protracted (4 month) strike during 1986 at the only other hospital in the City, leaving St. Mary's to care for the entire City for four months, our actual mortality rates were still within the predicted ranges established by H.C.F.A. for St. Mary's.

Again, I would like to thank you for the opportunity to review the H.C.F.A. mortality data in advance of its publication.

Sincerely,

Sister Marguerite Waite

Sister Marguerite Waite, FACHE
Executive Director

St. Vincent's
Medical Center
2800 Main Street, Bridgeport, Connecticut 06606 / Phone (203) 576-6000

HOSPITAL SPECIFIC COMMENTS ON HCFA MORTALITY DATA RELEASE

St. Vincent's Medical Center participates in a community based hospice program. This means that St. Vincent's receives patients whose prognosis is terminal. This has especially impacted the death rate for patients in the Cancer category.

Using the principle diagnosis to categorize patients can be misleading. In the case of St. Vincent's Medical Center, this has occurred in the category "Low Risk" Heart Disease. Having one of Connecticut's six cardiac surgery programs, many patients are admitted to St. Vincent's for open heart surgery (a factor not adjusted for in this analysis) whose principle diagnosis technically places them within the category of Low Risk Heart Disease. Based upon our review of the cases included in the analysis and adjusting for this factor, the mortality rate would be 4% instead of the published 7%.

This type of problem and another is true of the category Gynecologic Disease. The published mortality rate of 3% represents a single case and not our experience with a large number of patients. In this single case, the cause of death was a terminal Cancer condition not the result of Gynecologic Disease.

The HCFA analysis has an additional limitation related to the source of the information about the patient. The document used limits the number of diagnoses or problems encountered by the patient to a maximum of five. This presents an incomplete picture as exemplified by the patients included in the Pulmonary Disease category from St. Vincent's. Our more extensive analysis has indicated that many of these patients have significantly more problems than the government's source of information has indicated. At least 27% of the reported deaths occurred in patients who were so severely ill and having so many more medical problems at the time that they were admitted as to have little or no chance of survival.

With regard to the category Severe Trauma, we feel it important for the reader to recognize that many patients included in this category did not suffer the type of injuries that would be connoted by the phrase Severe Trauma (e.g., Motor Vehicle Accident, Violent Crimes, etc.). In fact, all of the nine deaths within this category were related to fractures resulting from falls prior to admission in patients already having severe disease of an unrelated nature.

Dennis Shrauger
Vice President
Medicare Provider No. 07-0028
10/26/87
Conducted by the Daughters of Charity of St. Vincent De Paul
An Affiliated Hospital of The Yale University School of Medicine

The Stamford Hospital

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Baltimore, Maryland 21201

Dear Dr. Roper:

We have carefully reviewed the mortality data for our hospital which was recently provided by HCFA. These statistics indicate that the mortality rate at The Stamford Hospital, for all diagnostic categories included, is well within the predicted mortality range.

At The Stamford Hospital, we thoroughly review the care which we provide to all patients. A number of clinical indicators, including mortality, are used to screen all records for quality, appropriateness of care, and service rendered. All deaths are reviewed through the peer review process.

The HCFA statistics provide us with another opportunity to review our care, because it includes mortality statistics for deaths which did not occur in the hospital, but did take place within thirty days of the patient's admission to the hospital. As a result, we have initiated a review of these cases with regard to discharge planning and clinical status at time of discharge. We are certain that this review will provide us with additional valuable information.

We have also used the HCFA data, and the Connecticut Hospital Association data, to compare our hospital with others in the state as regards mortality rates. This comparison is an interesting indicator, and is helpful for overall quality review.

We appreciate the opportunity to comment on this data, as well as the confirmation it provides of the quality of care delivered at The Stamford Hospital.

Sincerely,

Philip D. Cusano
President & C.E.O.

jbs

A Subsidiary of the Health Corporation of Greater Stamford

P.O. Box 9317 Stamford Connecticut 06904

64 ROBBINS STREET, WATERBURY, CONNECTICUT 06721
WATERBURY HOSPITAL HEALTH CENTER
JOHN H. TOBIN, President

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health and
Human Services
Health Care Financing
Administration
Washington, D.C. 20201

Dear Dr. Roper;

RE: Response Mortality Data from Medicare Provider #070005

The Waterbury Hospital Health Center is in receipt of the HCFA 1986 Medicare Mortality Data and finds it to be accurate as to the number of deaths occuring during hospitalization.

The HCFA data indicates the mortality rates for this hospital in each broad diagnostic category fall within predicted ranges. This hospital has always used morbidity and mortality data in on-going criteria based review activity. Although we cannot duplicate your study model, our internal review findings have been satisfactory. We will use the HCFA data as another focus in our review process. However, mortality review is only one of many indicators needed to assess health care outcomes.

We sincerely hope that in publishing mortality rates, you will be providing sufficient information on the importance of severity of illness, comorbid diseases, age, and socioeconomic status so that the public can interpret the statistics in a meaningful way and arrive at appropriate conclusions.

Sincerely,

John H. Tobin
President

The William W. Backus Hospital

Michael T. Moore, Chief Executive Officer

326 Washington Street, Norwich, Connecticut 06360, Phone (203) 889-8331

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Medicare Provider No. 070024

Dear Doctor Roper:

On behalf of The William W. Backus Hospital, I thank you for the opportunity to offer comments on the upcoming release of HCFA mortality data on Medicare patients. The Board of Trustees, Medical Staff and Administration of this hospital are committed to providing the highest quality care for all patients, and we welcome assistance in maintaining this commitment.

The William W. Backus Hospital has an extensive quality assurance program, based on ongoing objective and systematic monitoring of the quality and appropriateness of all patient care. Patient records are routinely screened for indicators such as readmission, unplanned return to the operating room, unnecessary surgery, complications, and death. The mortality data prepared by HCFA are another tool which can be used in this peer review process.

It is significant to note that the HCFA mortality data are only one element in this quality assurance process. In and of themselves, the mortality data are not an indicator of quality, rather they serve to highlight areas where quality problems might exist. At The William W. Backus Hospital, we firmly believe that their value is only as a form of ongoing monitoring, allowing us to evaluate the quality of care and clinical competence of providers and to assure quality.

The hospital is concerned, however, about the potential for reliance on these mortality data as an absolute indicator of quality, especially by consumers. The statistical model developed by HCFA does not measure such important patient specific factors as severity of illness, general health status, secondary diagnosis, or whether the patient had been transferred from a nursing home. While these factors can be of critical importance in individual risks for mortality, they have little bearing on the institution's quality of care. Failure to account for them may artificially inflate mortality rates, while not indicating anything about hospital quality.

In summary, we are pleased that HCFA has taken the effort to assist hospitals in quality assurance endeavors. We urge caution, however, in the use of these Medicare mortality data: they are not measures of performance or indices of quality; they are simply another screening tool for use in hospitals' quality assurance activities.

Thank you for the opportunity to provide these comments.

Sincerely,

Michael T. Moore
President and Chief Executive Officer

MTM/jws

WINDHAM COMMUNITY MEMORIAL HOSPITAL, INC.
and HATCH HOSPITAL CORPORATION
WILLIMANTIC, CONNECTICUT 06226 • (203) 423-9201 •

October 15, 1987

William R. Roper, MD
Administrator
Health Standard and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: HCFA Mortality Data; Medicare Provider # 070021

Dear Dr. Roper:

The following information is provided in response to the recently released HCFA Mortality Data.

Windham Community Memorial Hospital, Inc., and Hatch Hospital Corp., has had in place for several years a comprehensive Quality Assurance Program. One component of this program is 100% mortality case review, which is augmented by specialized peer review in certain areas, for example mortality review of acute myocardial infarctions by cardiologists. We do not rely heavily on raw data, such as mortality statistics, as an indicator of quality. Rather, it is the critical medical management, reviewed on a case by case basis by peers, that assures us of the quality of the care provided.

Regarding the methodology employed by HCFA to derive mortality rates within disease-specific categories, we would like to make the following comments:

1. Although HCFA has included certain covariants in its methodology, no true adjustment has been made for severity of illness. Thus, the probability factor of death occurring as a result of end stage illness is not defined within these broad mortality statistics. Death, in fact, may very well have been the expected outcome in most cases.

2. Stage of illness also has not been adequately accounted for in the HCFA Mortality Data. A large percentage of elderly patients experienced multiple body system failure and, although HCFA chose to attribute those deaths to a particular disease entity, mortality in these cases may have resulted from multiple factors, resulting in what may be artifically categorized mortality rates.

FRANK R. SEAFORTH President | **SUSAN A. ANDERSON** Vice President | **DOROTHEA B. FISCHER** Secretary | **DONALD K. HODGINS** Treasurer

3. The HCFA disease categories represent the principle reason for hospitalization and treatment and not necessarily the primary cause of death. HCFA information is derived from Medicare bills which contain diagnostic coding information restricted by certain medical record coding guidelines and regulations. What is of great significance is the absence of key clinical findings determined immediately prior to death or at the time of autopsy. As an example, a patient listed under the low risk heart disease category actually had a sudden, catastrophic event and at autopsy it was determined that the cause of death was a massive CVA. Variations between actual cause of death by autopsy or key clinical findings and death according to HCFA categorizations tend to invalidate the use of this data as measurements of true clinical mortality rates.

Regarding category - specific mortality rates, we would like to make the following comments:

CA (Cancer)

1. Windham Community Memorial Hospital has an active hospice program which allows patients to remain in their area of residence for both acute treatment and supportive terminal care.

2. Of the 17 CA deaths, 13 patients, or 76%, had a Do Not Resuscitate order entered in their medical record during hospitalization, indicating that death was the expected outcome.

CE (Stroke)

1. Of the 13 CE deaths, 10 patients, or 77%, had a Do Not Resuscitate order entered into their medical recording during hospitalization, indicating that death was the expected outcome.

GI (Gastrointestinal Disease)

1. Of the 7 GI deaths, 4 patients, or 57%, had a Do Not Resuscitate order entered into their medical record during hospitalization, indicating that death was the expected outcome.

2. As examples of the need to better quantify stage and severity of illness, three patients had other acute medical problems that had a direct relationship to the clinical outcome, as follows:

   - Acute renal failure secondary to acute tubular necrosis
   - Cardiac arrest secondary to massive pulmonary embolism
   - Cancer of the rectosigmoid junction

HL (Low-Risk Heart Disease)

1. Of the 6 HL deaths, 3 patients, or 50%, had a Do Not Resuscitate order entered in their medical record during hospitalization, indicating that death was the expected outcome.

2. As examples of the need to better quantify the stage and severity of illness, these same three patients had other acute medical problems that had a direct relationship to the clinical outcome, as follows:

   - Massive intracerebral hemorrhage (by autopsy)
   - Acute myocardial infarction
   - Cardiomyopathy, recent myocardial infarction

3. As explained later, one patient was alive and admitted to this hopsital in January, 1987 and obviously should be deleted from this mortality category.

HM (Severe Chronic Heart Disease)

1. Of the 11 HM deaths, 8 patients, or 73%, had a Do Not Resuscitate order entered into their medical record during hospitalization,indicating that death was the expected outcome.

2. As examples of the need to better quantify stage and severity of illness, four patients had other acute medical problems that had a direct relationship to the clinical outcome as follows:

   - End stage cardiomyopathy, renal failure, cirrhosis, encephalopathy
   - Superior mesenteric artery thrombosis (by autopsy)
   - Myocardial infarction with cardiac arrest
   - Heart wall aneurysm

ME (Metabolic and Electrolyte Disorders)

1. Of the 5 ME deaths, 3 patients, or 60%, had a Do Not Resuscitate order entered in their medical record during hospitalization, indicating that death was the expected outcome.

2. As examples of the need to better quantify stage and severity of illness, four patients had other acute medical problems that had a direct relationship to the clinical outcome, as follows:

   - Severe ischemic cardiomyopathy with cardiac cachexia; status post rectal cancer (by autopsy)
   - Lymphoma; cancer of the bladder
   - Adenocarcinoma of the prostate; renal failure
   - Glioblastoma

PN (Pulmonary Disease)

1. Of the 29 PN deaths, 18 patients, or 62%, had a Do Not Resuscitate order entered into their medical record during hospitalization, indicating that death was the expected outcome.

2. As examples of the need to better quantify stage and severity of illness, eight patients had other acute medical problems that had a direct relationship to the clinical outcome, as follows:

   - Coma secondary to CVA
   - Cancer of the lung
   - Mesenteric artery occlusion
   - Mucinous adenocarcinoma of the stomach with metastasis
   - Cancer of the prostate
   - Metastatic renal cell carcinoma
   - Lung cancer; bone cancer
   - Acute myocardial infarction

3. All patients in this category had between two and twelve comorbidities. Using only one patient as an example, it is difficult to understand clinically why this death in particular, as well as other deaths, should be characterized under the pulmonary disease category. This one patient had, in addition to pneumonia, acute myocardial infarction, pulmonary edema, coronary atherosclerosis, cerebral vascular disease, primary cardiomyopathy, endocarditis, cardiac dysrhythmias and convulsions.

SE (Sepsis)

1. Of the two patients in this category one also had thrombocytopenia and lymphoid leukemia; the other patient had lymphoma.

HCFA data has been reviewed for accuracy by this hospital. We respectfully submit the following corrections:

1. Two patients [redacted] are listed as expired the day after discharge. These patients actually expired while in the hospital.

2. One patient [redacted] is listed as having his last hospital admission in 1986, while this patient's actual last Windham Hospital admission occurred on January 4, 1987. This patient should be deleted from the HL category.

3. Two patients [redacted] left "Against Medical Advise." These patients should be deleted from the data base.

Windham Community Memorial Hospital Inc., and Hatch Hospital Corporation is pleased that we have been allowed this opportunity by the Health Care Financing Administration to review and comment on these mortality statistics prior to their public release.

Very truly yours,

Fred Hyde, MD
Administrator

Gerald O'Brien, MD, F.A.C.C.
Coordinator of Professional Services

Annette Hansell
Director of Quality Assurance

WINSTED
MEMORIAL
HOSPITAL

115 SPENCER STREET • WINSTED, CT 06098 • 203/379-3351

October 23, 1987

Medicare Provider #07-0026

Director
Health Standards & Quality Bureau
H.C.F.A.
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir/Madam:

Thank you for providing the 1986 Medicare Mortality data in advance and offering providers the opportunity to make comments and suggest corrections to the data. All of the cases identified in our data have been reviewed as an ongoing part of our quality assurance program.

Correction: [redacted] - This patient is under the GC (Gastro-intestinal Catastrophes) diagnostic category and from a review of this case it is our judgement that it should be included in the CA (Cancer) diagnostic category since this semi-urgent admission was a palliative surgical procedure necessitated by the patient's advance cancer.

Comments:

CA (Cancer) diagnostic category -

Even though we are well within the predicted range of mortality rates for this diagnostic category our rate is affected by our ability to provide terminal (hospice-like) care to these patients.

TR (Severe Trauma)

Our severe trauma mortality rate is well within the predicted range for our patient population

> but it is difficult to impute much validity to the rate because of the very small number of cases involved. (2 deaths out of 16 patients means that one death more or less would correspondingly raise or lower the mortality rate by 6.25%).

I would caution reviewers of the data that mortality rates are not specific indicators of the quality of care provided by hospitals.

Thank you again for affording us the opportunity to comment on this mortality data.

Sincerely,

Paul E. Graff
President

PEG:eac

Yale New Haven
1826 Hospital
20 York Street, New Haven, CT 06504

JOHN E. FENN, M.D.
CHIEF OF STAFF

October 27, 1987

Dr. William Roper
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

We are pleased to respond to your request for comments regarding the data our Hospital received on September 23, 1987 concerning Medicare mortality rates within 30 days of Hospital admission of Medicare beneficiaries. It is clear that the evaluation of quality of medical care is one of HCFA's highest priorities and I assure you that it is the highest priority of Yale-New Haven Hospital as well. It is my hope that my comments will assist HCFA in its attempt to enhance its quality assurance efforts. I would initially like to share with you some of the problems that we uncovered in trying to validate the statistics we received, and then would like to comment more globally on the methodology used to evaluate Yale-New Haven Hospital's quality of care.

In an effort to recapitulate the methods used in the HCFA analyses, we not only used the textual information provided in your cover letter and in the Federal Register, but also used the data presented to us. These data showed several patients who had been admitted in 1985 and had died in 1986, but showed no patients who had been admitted in 1986 and died in 1987. Thus, for our analysis, we assumed that any patient admitted within 30 days of his death would be counted, as long as his death occurred on or after January 1, 1986. Furthermore, we assumed that patients whose deaths or discharges occurred after December 31, 1986, were not counted in this analysis, whether or not they had died or lived. These assumptions differ somewhat from textual instructions, but are the only way to explain the data

which were presented to us. Data from our Hospital Information System, which is verified in a variety of ways, show 24.9% more Medicare admissions in calendar year 1986 then your records indicate. Using DRG and ICD-9 categories, we have attempted to see whether the data discrepancies settle in any particular subcategory of your analysis and we have not found this to be the case. Furthermore, there are similar discrepancies in the number of patient deaths throughout all subcategories of your analysis, as well as the summary statistics. Given that relatively small changes in overall mortality rates can totally change the way that the public and Federal Government look at individual hospitals, it is of utmost importance to rectify the differences between the data presented to us and the data which we possess.

It is also extremely important to make several observations concerning the use of mortality rates as a quality assurance indicator. Traditionally, investigators in the quality assurance area have avoided using mortality rates as an indicator of quality of care. This has largely been due to the fact that there are many factors which influence the time at which a patient dies, none of which are easily available through the UB 82 discharge abstract or any other information that is readily available on a national basis. For example, if a hospital implements a Do Not Resuscitate policy, its patients might die earlier rather than being put through weeks of unnecessarily heroic and uncomfortable care. Given your criterion of only counting deaths within 30 days of admission, hospitals that unnecessarily prolong the life of patients with terminal illnesses would appear to be high quality hospitals, a label which many physicians and community leaders would debate. In addition, the ICD-9 codes used for the clinical adjustment of mortality rates do not allow the severity of a patient's illness to be accurately gauged. While it is true that this data may be better than none at all, patients with coronary artery disease could vary from having very stable angina pectoris, which has an excellent prognosis, to having very severe disease with a poor prognosis and still receive the same ICD-9 comorbidity code. Thus, a hospital that tends to overcode or maximally code all comorbid illnesses (a practice which many in HCFA have called "gaming" the system) would appear as a high quality hospital because its patients who appear more ill by coding would have the very low mortality rates expected of patients whose illnesses are indeed mild.

At a more basic analytic level, the data provided by HCFA do not allow recapitulation and checking of your statistical models. Regression coefficients for your analysis are not included in any of the materials received by hospitals, so we are unable to check your statistical activities. This is especially disconcerting given the almost 25% error rate discussed earlier. Other criticisms of the method employed include:

1. The lack of additional complexity weight for patients having surgical procedures (indeed surgical procedures seem completely ignored).

2. In that a patient is at risk for death every time he comes into the hospital, the policy of using individual patients rather than admissions in the denominator is questionable.

3. The model has not been tested and validated in a controlled setting.

4. The control and validation of out-of-hospital deaths may not necessarily be a problem related to the last discharging hospital.

In summary, our effort to validate the information supplied to our Hospital by HCFA have demonstrated such severe variation that we have little confidence in the veracity of the overall process. Furthermore, for reasons outlined above, there appear to be many factors, not discernible from current databases, which could impact on overall mortality rates in a variety of ways, making these rates less than ideal quality indicators.

Finally, if HCFA wishes to enhance further the quality review process, it is of paramount importance to include enough data concerning the statistical modelling process for hospitals to check the overall derivation of the final statistics.

Yale-New Haven Hospital remains strongly committed to providing the highest quality of care to our patients. Despite our very favorable performance, as gauged by the recently presented HCFA

statistics, we have grave doubts concerning the accuracy and validity of the overall process. We are pleased to assist HCFA in any fashion in order to develop quality assurance indicators which will accurately reflect the care which is delivered to our hospitalized patients.

Sincerely yours,

John E. Fenn, M.D.

JEF:pm

cc: William B. Crede, M.D.
Medical Director, Quality Assurance
Yale-New Haven Hospital

C. Thomas Smith
President
Yale-New Haven Hospital

Vincent Prota
Vice President
Planning and Regional Affairs
Connecticut Hospital Association

Delaware

DE-1

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	Comment/ Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BEEBE HOSP OF SUSSEX CNTY LEWES DE 19958	DE-3	1334	12	10-17	95	31	17-38	64	14	19-42	36	11	5-31	73	23	14-34	86	34	30-52	18	11	4-42	113	11	12-28
KENT GENERAL HOSP INC DOVER DE 19901	DE-4	1679	15	9-16	140	24	14-32	68	21	17-39	56	16	7-29	66	24	15-37	89	45	27-48	20	20	5-41	142	27	14-30
MEDICAL CENTER OF DELAWARE WILMINGTON DE 19899	DE-5	5999	12	9-16	546	25	20-33	213	24	21-34	148	21	11-27	284	20	17-28	260	37	30-45	106	23	12-32	423	17	14-24
MILFORD MEMORIA HOSPITAL I MILFORD DE 19963	DE-6	1338	14	9-16	108	30	19-39	50	24	17-42	30	17	6-35	88	27	15-33	49	43	27-55	25	20	7-41	137	17	11-26
NANTICOKE MEMORIAL HOSP IN SEAFORD DE 19973	DE-7	1112	15	9-17	53	34	18-44	45	40	19-46	24	25	6-38	52	31	14-38	57	46	26-53	48	23	9-35	102	20	11-28
RIVERSIDE HOSP WILMINGTON DE 19802	DE-8	472	9	6-14	15	13	6-47	14	21	10-55	12	25	3-47	31	19	9-37	13	23	14-62	16	6	5-46	34	12	8-36
ST FRANCIS HOSP INC WILMINGTON DE 19805	DE-9	3130	11	8-14	225	18	14-30	124	29	19-36	60	23	10-32	200	20	15-28	130	29	28-47	73	18	12-34	213	10	13-26

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BEEBE HOSP OF SUSSEX CNTY LEWES DE 19958	16	31	9-55	23	52	20-60	25	0	2-27	5	0	0-100	126	3	2-11	40	5	0-19	12	0	0-100	132	1	2-10	43	2	0-17
KENT GENERAL HOSP INC DOVER DE 19901	15	60	10-58	28	36	19-55	49	6	2-19	12	0	0-99	144	10	2-11	135	4	1-11	12	0	0-99	129	5	2-10	68	1	0-11
MEDICAL CENTER OF DELAWARE WILMINGTON DE 19899	58	28	12-43	76	51	28-54	164	4	4-14	117	0	0-7	555	5	3-8	218	5	2-10	71	0	0-21	569	4	3-7	339	3	1-5
MILFORD MEMORIA HOSPITAL I MILFORD DE 19963	13	31	8-58	22	41	18-58	29	3	3-28	.	.		113	7	1-10	88	2	1-13	7	0	0-97	119	6	2-10	67	0	0-9
NANTICOKE MEMORIAL HOSP IN SEAFORD DE 19973	13	38	8-58	11	45	16-70	26	15	2-28	.	.		125	5	2-11	54	6	1-17	9	0	0-69	93	3	2-12	44	0	0-16
RIVERSIDE HOSP WILMINGTON DE 19802	4	50	4-79	5	0	6-76	8	25	1-53	3	0	0-100	51	12	1-15	22	9	1-29	4	0	0-100	60	2	1-14	42	0	0-16
ST FRANCIS HOSP INC WILMINGTON DE 19805	29	17	11-49	19	58	19-62	106	9	3-16	11	0	0-99	371	5	3-8	134	4	1-11	28	0	0-39	235	3	2-8	238	2	0-5

*Written Comments Not Submitted.

Beebe Hospital
OF SUSSEX COUNTY, INC.
LEWES, DELAWARE 19958
TELEPHONE (302) 645-3300

JAMES A. BALL
ADMINISTRATOR

October 22, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Re: Medicare Mortality data for Beebe Hospital
of Sussex County, Delaware
Medicare provider number 080007

Dear Dr. Roper:

We appreciate the opportunity to respond to the release of data on Medicare mortality rates at our hospital during 1986. We are encouraged that HCFA is employing a more mature methodology to determine mortality rates among Medicare patients. We hope that eventually the data will also reflect the severity of illness of our patients, as well. We think that mortality rates are more useful indicators when viewed in light of how sick the patients are at the time of admission to the hospital.

Our Medical Records Director has verified that, with minor exceptions, the data is accurate. Clinical and administrative staff at the hospital, including the Director of Hospital Quality Assurance, the Director of Utilization Review, the physician members of the Utilization Review Committee, the President of the Medical Staff, and the hospital administrators, have carefully reviewed the mortality data reported by HCFA. The clinical records of all the cases identified have been reviewed.

The hospital's Medical Audit Committee, made up of physicians on the medical staff, has for many years reviewed every death occurring at our hospital. This review occurs on a regular basis, every month. With two exceptions, all of the 1986 Medicare deaths had already been reviewed by this committee, against physician - determined standards of appropriateness of care.

Beebe Hospital's actual mortality rate for each of HCFA's sixteen patient categories fell within HCFA's predicted range. Most of the hospital's rates fell close to the lower end of those ranges. Our overall Medicare mortality rate of 12% was substantially closer to the low end prediction (10%) than to the high end of the range (17%). We think this is important in light of our review of records: 76% of the Medicare patients who died at our hospital in 1986 were so ill when they were admitted that death was an expected outcome of their hospital stay. Many of these patients were dying of cancer, or had overwhelming medical problems. Their average age was 76 1/2. In 64% of these cases, the patient and/or family members requested "No Code". We think these observations are reliable indicators of the severity of illness exhibited by the patients in our mortality data.

Beebe Hospital has served the people of Sussex County since 1916. Providing high quality medical and nursing care has always been our most important job. We are committed to keeping it our most important job now, and in the future.

Thank you for the opportunity to present this response.

James A. Ball
Chief Executive Officer

Bhaskar Palekar, M.D.
President of the Medical Staff

cc: Mr. Ball
Dr. Palekar
Mr. McDole
Ms. Richter

KENT GENERAL HOSPITAL, DOVER DELAWARE
H.C.F.A. MORTALITY DATA RESPONSE
EXECUTIVE SUMMARY

This report is a reply to the September 21, 1987 mortality data scheduled to be released in December by the Health Care Financing Administration (H.C.F.A.) section of the Department of Health and Human Services. Exception is taken with the H.C.F.A. logic, numbers and model used in their exercise.

Kent General Hospital is designated as a Rural Referral Center by H.C.F.A. which, by definition, is an indication of high numbers of acute care admissions. Our acuity level indicates generally that the Medicare group are even higher risk patients due to the severity of illness or injury on admission. The H.C.F.A. model does not include this severity of illness information.

PATIENTS TRANSFERRED

Patients transferred in for the following specialty services carry an even higher risk of mortality due to the condition being treated and to the fact that the patients arrive in an already complicated and/or compromised state.

NEUROSURGERY:	Brain tumors, trauma.
VASCULAR-THORACIC:	Trauma, aneurysms, by-pass (veins).
END-STAGE RENAL DISEASE PROGRAM:	Acute renal failure, sepsis, cerebral vascular accidents, and uncontrolled hypertension. Dialysis.
CANCER TREATMENT:	The Central Delaware Oncology Center is a resource for both in and outpatient radiation therapy. The hospital also offers chemotherapy.
HOSPICE:	Although a separate entity from the hospital, the on-site Hospice service provides care to terminally ill patients wishing to remain at home. Often the patients are discharged from the hospital only to die at home in a few days as expected.

Kent General is also the exclusive referral center for more than 1,100 nursing home beds in Kent County. Many of these patients may be transferred to Kent General in a critical stage of their illness with reduced probability of survival.

Therefore, H.C.F.A. model does not include these severity of illness impactors. Among many other contributing factors are the stage of the patient's illness and the patient's general health status.

H.C.F.A. contends that the cases average out. However, as hospitals lose income using H.C.F.A.'s "average", H.C.F.A. will actually be advantageously compensating those hospitals who are unable to treat complexly ill patients and penalizing hospitals who admit the very ill.

THE QUALITY ISSUE

The H.C.F.A. mortality rates by themselves do not measure quality. Such data may be appropriately used to assist in guiding or focusing peer review which is one form of quality assurance. Quality of care is the foremost concern at Kent General. Any indication of potential quality problems, including a mortality rate which is higher or lower than predicated, leads to prompt investigation to determine if a problem in fact exists. Identified problems are responded to appropriately and in a timely fashion.

The model used by H.C.F.A. has only questionable ability to detect differences in quality. The model has not been evaluated. A higher than expected mortality rate is no more than an indication of <u>possible</u> quality problems. It does not suggest that quality problems are <u>probable</u>, let alone <u>confirm</u> quality problems. The existence of quality problems can only be determined by an in-depth review of medical records, regardless of how rates of adverse occurrences compare with a national average, adjusted or unadjusted. That type of in-depth review is and will continue to be conducted by Kent General Hospital.

As H.C.F.A. presents their data, we could accept it carte blanche and suggest we are doing well. However, because this data is not a measure of quality, we prefer to continue our 100% review of charts to ensure accurate and up-to-date information and data by which we can measure and enhance the quality of patient care provided at Kent General Hospital.

STATISTICS

The source of the figures provided by H.C.F.A. is the U.B. 82 billing document provided to the Medicare intermediary payor within each State. For our state this is Blue Cross of Delaware. The source of the deaths was the Social Security Administration.

Several figures supplied by H.C.F.A. are questioned. They include:

1. The total number of final discharges.
2. The number of patients actually expiring at Kent General.
3. The number of patients who expired after discharge from Kent General.
4. Several dates of death.

MODEL PROBLEMS

Several concerns exist over the design of the model. H.C.F.A. includes deaths occurring after discharge. Many of these patients, as indicated by the total number of admissions, may have been successfully treated for their primary diagnoses and then discharged. The actual cause of death may have been a different diagnosis. Interestingly, the actual cause of death is not entered into the H.C.F.A. analysis because the patient may have died from a secondary cause, and H.C.F.A. does not know the cause of death. Another difficulty is that the Hospital cannot always control post-hospitalization care. Thus, we feel it is inappropriate to count post-discharge deaths in these statistics.

Also, the H.C.F.A. model only accounts for the last discharge. This ignores many successful admissions and discharges. A critical analysis was performed on five of the categories exhibiting a high mortality rate and/or frequency of cases as reported by H.C.F.A. (Please see Attachment "1"). This analysis demonstrates that if all discharges were included, the actual Kent General Hospital mortality rate would be significantly different.

There are patients who, on admission, are expected to die. A 100% review of deaths for 1986 has shown that 89.6 of our Medicare mortalities were anticipated at the time of admission. Many of these patients and/or their families, in consultation with their physician,requested that no extraordinary medical intervention be provided. This fact emphasizes the desire of these people to die with dignity

Finally of interest is the average age of Medicare patients dying at Kent General. Taken from the H.C.F.A. listing, Kent General compares favorably to the State of Delaware and national statistics for 1979-81 published in 1986.

	BOTH SEXES	MALE	FEMALE
State of Delaware	73.21	69.56	76.78
United States	73.88	70.11	77.62
Kent General Hospital	77.18	76.44	78.02

In summary, although we believe the public needs and deserves means by which to measure the quality of healthcare organizations, we believe H.C.F.A.'s methodology is inadequate.

ATTACHMENT "1" - COMPARISON

Category	H.C.F.A. Cases Final Discharge	H.C.F.A. Mortality Rate	Total Medicare Discharges	Total Medicare Mortality Rate	Range of H.C.F.A. Predicted Mortality Rates
- Cancer (Ca)	140	24%	255	13.3%	14 to 32%
- Gastrointestinal Disease (GI)	144	10%	258	5.6%	2 to 11%
- Severe Chronic Heart Disease (HM)	66	24%	107	14.8%	15 to 48%
- Severe Acute Heart Disease (HS)	89	45%	123	32.6%	27 to 48%
- Renal Disease (RN)	15	60%	22	40.1%	10 to 58%

CHRISTIANA HOSPITAL
EUGENE DU PONT MEMORIAL HOSPITAL
WILMINGTON HOSPITAL

THE MEDICAL CENTER OF DELAWARE

REPLY TO:
Executive Offices
P.O. Box 1668
Wilmington, DE 19899

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of hospital-specific mortality data for Medicare patients cared for by us during 1986. The Medical Center of Delaware is an 1100-bed Medical Center comprised of three hospitals. It is the largest provider of health care in the state and serves as a regional referral center for patients from Delaware, Maryland, New Jersey, and Pennsylvania. We are a teritary care facility providing care for patients that local hospitals cannot provide.

The physicians and the Administration of The Medical Center are committed to delivery of the highest quality care to our patients. To insure this, The Medical Center has a comprehensive quality assurance program which involves all of the Medical/Dental and professional departments. All of our patients' charts are screened to insure that the appropriate level of care is provided. If a quality of care issue is identified corrective action is quickly implemented and monitored.

The hospital-specific mortality data reported by the Health Care Finance Administration (HCFA) provides us with another tool with which to monitor our quality of care. However, we must point out that it is difficult to create homogeneous cells of patients all with the same severity of illness. Another problem is the small sample size of some of HCFA's diagnostic categories. In the case of The Medical Center several of these diagnostic categories have only one patient in them. This makes it difficult to generalize about institutional quality from the HCFA data.

The Medical Center of Delaware welcomes this report recognizing that it represents a start in developing more sophisticated quality care measures. Severity of illness indices which will enable us to compare our results with other hospitals are being developed in the United States and we look forward to the time when these measures will be incorporated in the HCFA data.

The data published by HCFA report has been reviewed by members of the Medical/Dental and Administrative Staffs of The Medical Center of Delaware and in all cases, falls within the predicted mortality ranges. We will continue to monitor all of our patients to insure the care they receive is at the appropriate level and type. As health care institutions continue to redefine the way we measure quality we will incorporate new tools into our review process.

We thank the Health Care and Finance Administration for the opportunity to provide this response.

Sincerely yours,

Allen L. Johnson
President and Chief Executive Officer

Edgar R. Miller, M.D.
President
Medical/Dental Staff

ALJ:ERM:jad

Milford
Memorial
Hospital

VHA
Partner–VHA Mid-Atlantic
Affiliate of the Voluntary
Hospitals of America System.

October 26, 1987 Medicare Provider # 080002

Health Care Financing Administration
Department Health and Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC

Milford Memorial Hospital wishes to submit the following comments regarding HCFA's release of hospital-specific mortality data.

Improvement in the quality of medical care delivered to all of our patients is a primary goal of Milford Memorial Hospital. Objective measurement, analysis and dissemination of information about quality is a key to achieving that goal. The release of data on quality performance to the public can promote consumer awareness of quality differences and may assist their decision-making. To that end, HCFA's publication of hospital mortality data **has the potential** of being a laudable effort.

Nevertheless, the reliability, accuracy and interpretation of such information is critical to the public's understanding and effective use of this data. Careful study of HCFA's methods in determining hospital mortality rates reveals significant limitations and inappropriateness as a quality indicator.

The mortality data released for Milford Memorial - while well within normal ranges - fails to consider a myriad of factors that may affect mortality. These factors may include, but are not limited to, a patient's age, general health status, severity and stage of illness, psychological condition, and compliance with prescribed treatment.

An integral part of Milford Memorial's quality assurance program is a thorough review of all hospital mortality, conducted on a monthly basis by our medical staff. This review and analysis of mortality data goes beyond the raw numbers and principal diagnosis, as HCFA considers, and looks at patients' "whole care." In this way, mortality can be better analyzed in terms of specific patient characteristics and treatment.

Clarke Avenue • Milford, Delaware 19963-0199 • 302/422-3311

In addition, there are many other quality indicators which are completely excluded from consideration by the HCFA data.

These may include medical staff background and areas of specializations, accreditation status, scope of service and numbers of procedures performed within specific categories. The Joint Commission on Accreditation of Health Care Organizations is also developing quality indicators as part of its hospital survey and accreditation process.

Quality judgments can only be made after a thorough review of all such information. The data released by HCFA may raise important questions, but it cannot answer them.

During the past several months, the methods and criteria used by HCFA in the release of mortality data has been scrutinized and criticized by numerous health care associations including the American Hospital Association, American Medical Association, Voluntary Hospitals of America, and others. Given this overwhelming skepticism of HCFA's mortality data, we encourage the general public and news media to exercise similar healthy skepticism.

While this data may be a starting point for discussion of quality issues, it is in no way a tool for measurement of quality. It is our hope that release of this data and its subsequent publication by the news media and interpretation by the general public leads to more open discussion of quality issues. It is our concern that the data will be used as a quantitative measure and ranking of hospitals' quality.

Milford Memorial Hospital has provided quality care to the residents of central and southern Delaware for more than 80 years. We respect the trust and confidence that our patients and community place in our services. Our quality assurance requirements reflect that trust and enable us to maintain our high standards of care.

We appreciate the opportunity to present our views on the release of this information.

Sincerely,

L. Glenn Davis

L. Glenn Davis
Administrator

St. Francis Hospital
Seventh and Clayton Streets
Wilmington, Delaware 19805

Office of President

October 21, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: HCFA Mortality Data Release
Medicare No. 080003

Dear Dr. Roper:

St. Francis Hospital welcomes the opportunity to comment on the Healthcare Financing Administration's mortality information planned for release in December 1987. Our comments will be directed to (1) hospital specific data, and, (2) general concerns with the release of such information in its present form.

As regards the hospital's specific information, your data indicates, as well as it is our belief, that St. Francis Hospital is experiencing a lower than average mortality rate in the designated categories. We are below the mid point of range in thirteen of the sixteen diagnostic categories. However, the overall mortality rate in the All Cases Category indicates that St. Francis is at the mid point of the range. We feel that this is one of the aberrations in the statistics methodology which needs to be corrected. It could easily be misinterpreted, especially for those hospitals that are elevated to a higher end of the expected mortality range by the current methodology.

A second concern is that of the 337 deaths of patients and former patients of St. Francis Hospital, your data indicates that 56 occurred post discharge. Hospital records indicate that 48 were post discharge, while the other 8 deaths did occur while still a patient (See Attachment 1). Of the 48 post discharge deaths, accurate verification as to the cause of death is most difficult. Death certificates often attribute the cause of death to respiratory arrest or heart failure, etc., and do not reflect the specificity of the diagnostic categories used in the remainder of the study, therefore leading to inaccurate categorizations as to the real cause of death in your data. If HCFA used data that was verifiable by the hospital's medical record, (i.e., only deaths that occurred <u>in the hospital</u> within 30 days of admission) these inaccuracies could possibly be overcome.

Another concern relating to the inclusion of post discharge deaths, is that they skew the hospital's mortality rate because it is possible that the patients died of causes unrelated to their hospital admission. Upon review of the 48 post discharge deaths, 25 were discharged to an extended care facility, 22 to a home health program and 1 refused follow-up services. All cases are reviewed by the hospital's Professional Activities Committee and PRO were found to be medically appropriate discharges to the next level of care. Having these deaths attributed to St. Francis Hospital mortality rates when they are not under our control we feel is inappropriate.

A fourth concern deals with the diagnostic category of Sepsis, where we were above the mid point of the range. Our first comment is that Sepsis is an inappropriate category, which like your unknown, is a potential "catch all". Secondly upon review of the cases in this category, over 75% of those patients were admitted in a septic condition, and were very complex medical cases. As indicated in your September 21 letter, you do not have the capability to incorporate severity of illness criteria in your data. Perhaps it would be best to leave such a diagnostic category out in future data releases because of the complexity of this broad based diagnostic category.

Our general concerns focus on two areas. First, future releases of data should consider total Medicare admissions for an institution. Many Medicare patients may have several related or unrelated hospitalizations during a year's period of time. The fact that these hospitalizations are not included in the case count certainly affects the mortality rate on an individual institution, especially those with a high Medicare utilization. Secondly, when data is released, the disclaimer regarding making comparisons among hospitals or relating this data to the quality of care must be very evident. Our previous experience with last year's disclosure suggests a need to emphasize this in the public forum.

St. Francis Hospital has always been known for its high quality of care. The population over age 65 affirms our dedication to them as they select us to be their hospital of choice in numbers clearly higher than a hospital of our size in our community would ever expect. We feel privileged to care for them in all stages of their life.

Again, we appreciate the opportunity to review and comment on the HCFA Mortality Data prior to its public release. We hope our comments have been constructive and will be considered for future data releases.

Respectfully yours,

Paul C. King, Jr.
President

PCK/mte
Attachment

ATTACHMENT 1

EXPIRED AT ST. FRANCIS HOSPITAL

PATIENT ID HIC NUMBER	PATIENT NAME	ADMISSION DATE	DISCHARGE DATE (ACTUAL DEATH)	HCFA DATA DATE OF DEATH
[redacted]	[redacted]	6/19	6/22	6/30
[redacted]	[redacted]	8/18	8/24	8/31
[redacted]	[redacted]	12/02	12/13	12/31
[redacted]	[redacted]	12/25	12/26	12/31
[redacted]	[redacted]	2/05	2/06	2/28
[redacted]	[redacted]	4/30	5/11	5/09
[redacted]	[redacted]	2/15	2/15	2/16
[redacted]	[redacted]	12/21	1/02	1/03

District of Columbia

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CAPITOL HILL HOSP WASHINGTON DC 20002	DC-3	1397	10	8-14	52	19	12-37	46	15	14-40	36	17	7-34	107	8	13-29	29	41	24-59	48	29	8-34	117	17	13-29
COLUMBIA HOSP FOR WOMEN WASHINGTON DC 20037	DC-4	59	0	1-17	15	0	3-43	.	.		1	0	0-98	.	.		.	.		.	.		.	.	
DISTRICT OF COLUMBIA GEN H WASHINGTON DC 20003	DC-5	816	17	7-15	47	34	13-39	31	19	12-42	29	28	7-37	57	14	11-32	21	38	19-59	39	28	5-32	58	33	8-29
GEORGE WASHINGTON UNIV HOS WASHINGTON DC 20037	DC-6	1957	8	8-14	201	19	15-32	44	14	15-41	51	18	8-32	88	10	13-31	52	25	24-51	48	25	9-36	112	20	14-31
GEORGETOWN UNIV HOSP WASHINGTON DC 20007	DC-7	2588	9	8-14	265	20	18-33	59	19	16-40	61	16	11-33	87	17	14-32	84	27	28-50	46	24	12-39	135	18	14-30
GREATER SE HOSP WASHINGTON DC 20032	DC-8	1625	11	9-15	79	23	17-39	52	42	17-42	36	19	8-36	104	23	14-31	36	39	22-54	77	17	9-31	126	20	15-31
HADLEY MEMORIAL HOSP WASHINGTON DC 20032	DC-9	275	13	7-16	8	38	4-59	6*	17	5-69	5	40	3-69	18	6	7-44	4	50	11-86	15	40	7-50	30	17	6-33
HOWARD UNIVERSITY HOSPITAL WASHINGTON DC 20060	DC-10	1513	11	9-16	145	28	20-38	56	13	15-39	20	25	7-44	124	17	14-29	37	27	25-57	38	5	6-33	115	23	12-29
PROVIDENCE HOSP WASHINGTON DC 20017	DC-11	2002	10	10-16	162	22	17-34	85	27	19-39	83	13	10-30	156	11	16-31	73	29	27-51	66	21	10-33	116	11	13-29
SIBLEY MEMORIAL HOSP WASHINGTON DC 20016	DC-12	2564	8	8-15	310	13	15-29	93	17	20-40	96	10	9-28	113	20	15-31	52	31	29-57	37	19	10-40	167	17	14-29
US AIR FORCE HOSP WASHINGTON DC 20331	DC-13	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
WASHINGTON HOSP CTR WASHINGTON DC 20010	DC-14	4349	9	8-14	424	20	17-31	125	22	19-36	59	15	9-31	191	15	14-27	144	34	30-48	78	14	9-30	167	14	11-25

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CAPITOL HILL HOSP WASHINGTON DC 20002	18	17	8-51	9	33	11-68	21	5	1-30	29	0	0-59	118	7	2-12	76	5	1-14	6	0	0-98	139	7	2-10	64	0	0-12
COLUMBIA HOSP FOR WOMEN WASHINGTON DC 20037	.	.		.	.		.	.		.	.		5	0	0-90	2	0	0-95	15	0	0-98	.	.		.	.	
DISTRICT OF COLUMBIA GEN H WASHINGTON DC 20003	10	0	2-55	11	64	14-68	11	9	1-44	5	0	0-99	48	8	2-18	35	3	1-21	3	0	0-100	92	9	1-11	21	5	0-40
GEORGE WASHINGTON UNIV HOS WASHINGTON DC 20037	17	24	4-48	8	50	10-69	49	8	3-21	52	0	0-20	140	5	2-11	97	3	1-13	10	0	0-98	160	1	2-10	158	0	0-6
GEORGETOWN UNIV HOSP WASHINGTON DC 20007	18	6	5-47	8	50	13-73	41	5	2-21	82	0	0-15	154	6	3-12	97	4	2-13	19	0	0-52	356	6	3-8	149	1	0-6
GREATER SE HOSP WASHINGTON DC 20032	32	9	8-44	18	33	16-59	18	0	1-32	3	0	0-100	97	4	3-15	93	6	2-15	10	0	0-99	145	6	2-10	78	0	0-10
HADLEY MEMORIAL HOSP WASHINGTON DC 20032	4	50	9-85	5	60	8-77	3	33	0-92	.	.		20	10	0-29	15	7	1-37	1	0	0-100	20	0	0-28	20	5	0-61
HOWARD UNIVERSITY HOSPITAL WASHINGTON DC 20060	24	21	8-47	25	32	17-55	25	8	3-30	18	0	0-82	113	7	2-12	58	2	1-16	7	0	0-99	170	2	2-9	34	0	0-26
PROVIDENCE HOSP WASHINGTON DC 20017	30	10	5-41	15	60	16-64	35	14	3-25	20	0	0-94	152	7	2-11	128	2	2-12	7	0	0-100	120	5	2-11	99	0	0-8
SIBLEY MEMORIAL HOSP WASHINGTON DC 20016	11	18	6-59	18	39	22-66	97	3	3-15	41	2	0-42	216	3	2-9	179	1	1-10	19	0	0-95	149	3	2-10	285	1	0-4
US AIR FORCE HOSP WASHINGTON DC 20331	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
WASHINGTON HOSP CTR WASHINGTON DC 20010	84	6	5-34	25	28	18-56	40	10	2-22	189	1	0-4	212	7	3-10	244	2	1-10	16	0	0-83	928	4	3-7	150	2	0-6

*Written Comments Not Submitted.

CAPITOL HILL HOSPITAL

700 Constitution Avenue, N.E.
Washington, D.C. 20002
(202) 269-8000

October 20, 1987

Dr. William L. Roper, Administrator
Healthcare Financing Administration
Department of Health & Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

We would like to express our appreciation for the opportunity to examine and verify the Medicare mortality data pertaining to Capitol Hill Hospital. We have high hopes that the data provided, although somewhat limited in detail, will enable us to better evaluate the quality of care provided at our institution.

Through our verification process, we were able to determine minor discrepancies in the data provided pertaining to in-hospital deaths. These discrepancies, however, are related primarily to bookkeeping-type variations such as a patient having been readmitted and died while in the hospital as opposed to having died post-discharge or upon errors in procedure code recordation. Accordingly, none of these discrepancies appear to produce any significant statistical deviation from the analysis provided by your agency. Naturally, as you have pointed out, it is extremely difficult to verify data for those individuals who have died following discharge from an institution. This is particularly true in an institution such as ours that serves such a large population of homeless and public shelter residents.

Again, we appreciate the opportunity to participate in any program that has a potential to assist us in our attempt to evaluate quality of services.

Cordially,

Bill Haire
President and Chief Executive Officer

Attachment
BH/HP/cg

Member of the Mediantic Healthcare Group

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Government of the District of Columbia
District of Columbia General Hospital
19th Street and Massachusetts Avenue, S.E.
Washington, D.C. 20003
Telephone (202) 675-5000

October 28, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Room 309-G Hubert H. Humphrey Bldg.
200 Independence Avenue, S. W.
Washington, D. C. 20003

Dear Dr. Roper:

The District of Columbia General Hospital emphatically disclaims the HCFA report on mortality rate within this hospital, primarily because the statistical method used is not valid and does not reliably predict mortality rates for this hospital.

There are more outstanding factors influencing the risk of death for the District of Columbia General Hospital patients than the set of patient characteristics used by HCFA to predict mortality. Such factors as the patient's general health status on admission, the stage of the patient's illness and the availability of support systems are responsible for significant deviations from the predicted mortality rates for the District of Columbia General Hospital.

The statistical model did not encompass medical record review. Judgment can only be made after reviewing information contained in a patient's medical record.

The data presented by HCFA indicate that a total of 816 Medicare patients were admitted to the District of Columbia General Hospital in 1986. 135 died within thirty (30) days of admission. Of the 135 identified, reportedly 126 died while still an inpatient, 9 died after discharge. Our review of your data reveals discrepancies which are significant and serious with respect to your conclusion. An analysis of our review is attached.

Hospital statistics indicate that a total of 1502 Medicare admissions occurred in 1986. We are not able to determine causes nor numbers of deaths after discharge, for that information is not available to hospitals. It is also inappropriate to apply these percentages carte blanc to an overall hospital rate when causes of death, post discharge, are not always identifiable and attributable.

In only one of the diagnostic categories did the hospital's actual mortality rate exceed the range of predicted mortality. However, the average rate for the District of Columbia General Hospital was calculated to be above the predicated range, suggesting that our overall mortality rate is high.

This situation demonstrates an artifact of the statistical technique used to generate the data. In truth, all category rates above the predicted rates require additional analysis to determine if the cases indeed, conform to HCFA characteristic criteria or possess other significant variances.

We thank you for the opportunity to express our concerns and opinions.

Sincerely,

John Dandridge, Jr.
Executive Director

JD/VRI/mjs

cc: The American Hospital Association
The National Association of Public Hospitals

ATTACHMENT I

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA In-hospital	Deaths Reported by HCFA Post-hospital	Deaths Verified by Hospital In-hospital	Deaths Verified by Hospital Post-hospital	Unable to Verify
CA -- Cancer	15	1	12	1	3
CE -- Cerebrovascular Accidents	5	1	4	1	1
GC -- Gastrointestinal Catastrophes	8	0	8*	0	-
GI -- Gastrointestinal Disease	4	0	4**	0	-
GU -- Urologic Disease	1	0	0	0	1
GY -- Gynecologic Disease	0	0	0	0	-
HL -- Low Risk Heart Disease	8	0	6*	0	2
HM -- Severe Chronic Heart Disease	8	0	7 (1 alive)	0	-
HS -- Severe Acute Heart Disease	8	0	7	0	1
ME -- Metabolic/Electrolyte Disturbances	10	1	9 (2*)	1	1 (N.H.)
OP -- Orthopedic Disorders	1	0	1*	0	-
PN -- Pulmonary Disease	17	1	15 (1 alive)	0	2
RN -- Renal Disease	0	0	0	0	-
SE -- Sepsis	6	1	4	0	3
TR -- Severe Trauma	1	0	1	0	-
OP -- Ophthalmalogic Disease	0	0	0	0	-
UN -- Other Diagnoses	33	4	31	2 (2 alive) (2 Nsg. Home)	3
Total -- All Categories	126	9	109	9	17

* Date of death different
** Diagnoses different

OF THE 9 PATIENTS DEEMED TO HAVE DIED AFTER DISCHARGE FROM DCGH:
- 3 sent to Nursing Home
- 2 sent home
- 2 unable to identify
- 2 alive after HCFA date

DC 5.2

THE
GEORGE
WASHINGTON
UNIVERSITY
MEDICAL CENTER

The University Hospital / 901 Twenty-third Street, N.W. / Washington, D.C. 20037

Administrator, Medical Center
(202) 994-2500

October 21, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Roper:

While we were pleased to see that The George Washington University Hospital (GWUH) did well in the statistics released by the Health Care Finance Administration (HCFA), we feel that the methodolgy, and therefore the data was flawed.

The data supplied by HCFA indicates that for the year 1986, a total of 164 Medicare patients admitted to GWUH died within 30 days of admission. Of these 164 patients, HCFA also states that 37 patients died after discharge. HCFA also classified these 164 patients into 16 diagnostic categories based on the admitting diagnosis. Further, based on the national statistics, GWUH was given a "Range of Predicted Mortality Rates" for each diagnostic category.

George Washington University Hospital was at the lower range or below the Range of Predicted Mortality in all but 5 diagnostic categories, and in these categories we were in the mid-range.

The records of 161 of the 164 patients were reviewed for appropriateness and quality of care. Of these 161 patients:

- 57 had admission diagnoses on their last admissions which were not indicative of the basic diseases causing death (i.e., an end stage renal disease patient admitted with acidosis and thus categorized as "Metabolic/Electrolyte Disorder" or a patient with cancer of the bowel who develops peritonitis and classified as "Septicemia").

- 75 patients had a "Do Not Resuscitate" order on the chart.

- 140 patients had severe disease in more than one organ system, whether by extension as in metastatic cancer, by association as in vascular compromise in both the brain and heart, or because of separate diseases, as with a cancer patient with coronary artery disease.

- 30 patients were under 70 years of age.

RECEIVED

With the high incidence of comorbidity, "Do Not Resuscitate" orders, and increased age, it would seem that the population identified by HCFA was predominately in the late stage of disease.

With a 35% discrepancy between the "final admission" diagnosis and the patient's basic disease, the data released do not give a true picture of GWUH's mortality in each diagnostic category. Further, if this inconsistency is true for other institutions, the methodology used in producing these statistics and the "Range of Predicted Mortality" is flawed and potentially quite misleading.

Sincerely,

Michael M. Barch

Michael M. Barch
Administrator, Medical Center

MMB/db

GEORGETOWN UNIVERSITY HOSPITAL

Charles M. O'Brien, Jr.
Administrator

October 27, 1987

Mr. Harvey Brook
Health Standards and
Quality Assurance Bureau
Room 2-D-2 Meadows East Building
6300 Security Boulevard
Baltimore, Maryland 21207

Medicare Provider Number: 090004

Dear Mr. Brook:

In reviewing the mortality data from the Health Care Financing Administration (HCFA) for the areas categorized we note that Georgetown University Hospital has consistently maintained a low mortality compared to actual.

While this is in keeping with our own Quality Assurance monitoring, we concur with HCFA's recognition of the significant limitations of the methodology used in compiling the data. We acknowledge HCFA's efforts in making the data as meaningful as possible and strongly support the need for developing and defining methodologies for measuring quality care.

However, there are a variety of important areas where use of this data on a national and hospital specific basis could be quite misleading. By national acknowledgement the current data does not adequately measure the severity of illness. Even the use of specific categories (as was applied in this study) does not sufficiently address this issue and therefore could be misleading, especially with regard those institutions that have a large percentage of patients with severe infirmities. Additionally, the site of care in various communities could significantly impact mortality rates, particularly in the area of cancer deaths which could reasonably be affected by an adequate hospice program (or lack thereof).

These are among the more significant limitations of the data. We would strongly support the proposition that HCFA work with various medical specialty boards, The Joint Commission on Accreditation of Health Care Facilities and other interested health organizations to develop more meaningful assessments of quality health care. The statistical methods employed in this study are crude at best. Additional study and investigation by individual institutions and their medical staff would better reflect the data at hand.

I do appreciate the opportunity to comment and review the data as presented.

Sincerely,

Charles M. O'Brien, Jr.
Hospital Administrator

CMO:btb

GREATER SOUTHEAST COMMUNITY HOSPITAL
RESPONSE TO HCFA MORTALITY DATA
Medicare #: 09008

Greater Southeast Community Hospital is committed to providing quality health care through various quality of care programs. Therefore, we support HCFA's effort to address the quality of care issues at a national level and we believe this review of hospital mortality data as it relates to Medicare patients is an excellent start. However, after review, we have found two limitations; accuracy of the data and the lack of a severity of illness adjustment in the statistical model. We expect that data will be more meaningful in future releases when these problems are resolved.

Review of the information provided to us from HFCA indicates that GSCH was within the predicted mortality range for all diagnostic categories and at the low end of the range for many. However, an area of concern to us was the category related to strokes (listed on the report as category CE). While the hospital was within the expected range in this category, HCFA figures show that we were in the higher range. Therefore, we examined each of the cases in the CE category, concentrating in three areas: data accuracy, severity of illness and medical management.

Data Accuracy: Of the 22 cases reported by HCFA, the cause of death in three cases was different from the principal diagnosis. One patient died from severe lung disease, one from pneumonia related to CE and one from a heart attack. Careful medical review indicates that in each case, medical management was appropriate and consistent with current standards of care.

Severity of Illness: The degree of advanced illness at the time of patient admission was significant and predictive of possible death. On admission, 15 patients were determined to be gravely ill and not likely to survive, even though aggressive treatment was given. The remaining 7 patients were deemed severely ill and at high risk for death. It should be noted that the liklihood of death did not affect the quality of medical and nursing care each patient received.

Medical Management: HCFA data also included patients whose death occurred after discharge. Our analysis of these cases shows that medical management and nursing care were clearly appropriate. Of the 18 patients in this category, one left the hospital against medical advice. The remaining 17 were medically stable and no further acute care treatment was indicated at time of discharge. In all cases discharge instructions were given and plans for follow up care were appropriate.

In addition to review of CE cases, GSCH reviewed all other categories and found that in a high precentage of those cases, the cause of death did not match the principal diagnosis by which the patient was categorized by HCFA. In other words, the cause of death may have been related to a different chronic condition present on admission. In eleven cases, we could not verify the principal diagnosis which was provided by HCFA. We also noted that in at least six cases, HCFA reported dates of death which did not match actual dates as recorded on death certificates.

The quality of care provided by hospitals is the single most important measure of a facility. We agree with Dr. Roper, HFCA's Administrator, when he stated "we cannot and do not recommend the use of the information by itself to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals". Because the information is intended for use by the public, it must be accurate. We believe that refinements to the statistical model and better methods of collecting and interpreting mortality data will increase the usefulness of future releases.

HOWARD UNIVERSITY HOSPITAL C AMO
2041 GEORGIA AVE NORTHWEST
WASHINGTON DC 20060 28AM

Western Union Mailgram®

4-0312395301 10/28/87 ICS IPMMTZZ CSP BALB
2027456100 MGMB TDMT WASHINGTON DC 129 10-28 0527P EST

HEALTH CARE FINANCING ADMINISTRATION
HEALTH STANDARDS AND QUALITY BUREAU
HOSPITAL MORTALITY INFORMATION
PO BOX 26684
BALTIMORE MD 21207

RE: 090003

ALTHOUGH HCFA ENDEAVORS TO INCLUDE A MEASUREMENT OF SEVERITY OF ILLNESS IN THE ALGORITHM FOR HOSPITALS SPECIFIC PREDICTED MORTALITY RATE IT IS OUR CONTINGENT THAT THE EXCLUSION OF RACE AS A DEMOGRAPHIC CONSIDERATION IN THE DEVELOPMENT OF THIS ALGORITHM IS A MAJOR ERROR, WHICH FURTHER COMPROMISES THE USEFULNESS OF THIS DATA AS A MEASURE OR INDICATOR OF QUALITY OF CARE. THIS ACTION BY HCFA IS WHOLLY DISCORDANT WITH THE REPORT OF THE SURGEON GENERAL WHICH DOCUMENTS A HIGHER MORTALITY RATE IN BLACKS AS COMPARED TO CAUCASIANS IN A NUMBER OF DISEASES, I.E., CANCER AND STROKE.
DON H WOOD MD CHAIRMAN
QUALITY ASSURANCE COMMITTEE
HOWARD UNIVERSITY HOSPITAL
WASHINGTON DC 20060

17:23 EST

MGMCOMP

5241 (R 7/82)

PROVIDENCE
HOSPITAL

October 26, 1987

William L. Roper, MD, Administrator
Health Care Financing Administration
Health Standard and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Provider #09-0006

Dear Doctor Roper:

We offer the following comments in response to the Providence Hospital HCFA Mortality Data submitted with your letter of September 21, 1987.

The HCFA mortality data can be used by hospitals, and will be used by Providence Hospital, as a basic screening tool to identify areas of medical care which, when supplemented with particular patient-specific information, may provide useful information.

In interpreting the mortality statistics, consumers should keep in mind that a mortality rate is not a measure of the quality of service provided; but rather one outcome or result of care which is dependent on many variables. These major variables include age and sex; general health status of the patient including all chronic illnesses he or she may have; the severity of the major illness for which the patient was hospitalized; and the care the patient received after discharge. The HCFA mortality rates do not account for all of these factors. Severity or seriousness of an illness, general health status of the patient, and the care the patient received after discharge, are not accounted for in computing the expected death rate. Severity of illness is a critical influence on the outcome of the care and would provide more meaningful interpretation and use of the data. For example,two patients whose principal diagnosis is pneumonia, can be at different stages of illness on admission to the hospital. One patient may be more seriously ill, while another may be in an earlier, more easily treatable stage.

Hospitals who care for large numbers of seriously-ill patients would be expected to have higher death rates although the reasons for the high rates would not be apparent from a review of the statistics.

1150 Varnum Street, N.E. Washington, D.C. 20017 202/269-7000
A Daughter of Charity Hospital Serving Metropolitan Washington, D.C. Since 1861

To further complicate matters, the data categories used by HCFA combine life-threatening illnesses with more chronic, non-acute illnesses in determining one mortality rate. This grouping is not useful for anyone who wishes to assess outcome for specific illnesses. Also, the mortality data is not based on the actual cause of death but rather the principal reason for the patient's hospitalization as determined by the attending physician and coded into the financial data base used by HCFA.

In reviewing Providence Hospital statistics, several errors were noted in the HCFA data. HCFA indicates that a total of 2,002 Medicare patients had their last admission of 1986 at Providence Hospital. Of this number, 198 Medicare patients died within 30 days of admission. Of these deaths, 169 died in the hospital and 29 died outside of the hospital.

We have no way of verifying that 2,002 patients had their last Medicare admission of 1986 to Providence Hospital, as we do not have access to the same HCFA data base. Providence Hospital records do indicate that of the 2,002 patients, 196 patients expired within 30 days of their last admission to Providence in 1986; (1 patient was still alive at the time of discharge and has had subsequent admissions to Providence in 1987 to validate this finding; 1 patient, no record could be found of admission or discharge). Of these 196 patients, 175 expired while still in the hospital and 21 patients died after discharge. These 21 deaths could not be validated as information concerning their death was not in the medical record. (8 patients expired while still in the hospital as opposed to expiration after discharge as stated in HCFA data)

An excellent example of why this data can not be used as a measure of quality care is Providence Hospital's mortality rate for the sepsis grouping of patients (i.e. patients diagnosed as having a life-threatening blood infection). Our actual mortality rate for this category of illness is 60%, which is on the higher end of the projected 16 - 64% interval. Of those 15 patients in this category who were treated, 9 patients died. 7 of the 9 patients who died, were unresponsive or comatose on admission, with documentation by the physician that the patient was not expected to survive the hospitalization. 5 of the patients were admitted from a nursing home and 4 were over the age of 80. All 9 patients died in the hospital.

In summary, the consumer must be aware of the limitations of the data before attempting to use the information as a means of quality assessment. The limitations stem from use of an incomplete data base which was designed by HCFA for financial and claims administration and not for evaluation of the clinical care provided.

Thank you for the opportunity to respond to this information.

Sincerely,

Sister Catherine Norton
President

SCN:elr

5255 Loughboro Road, N.W.
Washington, D.C. 20016
Telephone (202) 537-4680

Chief Executive Officer

Sibley Memorial Hospital

October 26, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

re: Comments on 1986 Medicare Mortality Statistics for
Sibley Memorial Hospital, Medicare provider, No.090005

Dear Dr. Roper:

The data provided by the Health Care Financing Administration (HCFA) of the Medicare participants whose last hospital admission to Sibley was in 1986 and who died within 30 days of that admission was reviewed by the staff of Sibley Memorial Hospital. We were pleased that Sibley's Medicare mortality rate for all causes was at the bottom of the range of predicted mortality rates, and that the mortality rates for all 16 diagnostic categories compared favorably to the range of predicted mortality rates by either being below the range or in the low end of the predicted range. However, we did conduct detailed medical records reviews for fifty nine cases in the following selected diagnostic categories which had higher actual mortality rates in comparison to the range of predicted rates: Ophthalmologic Disease, Severe Chronic Heart Disease, Severe Acute Heart Disease, Metabolic/Electrolyte Disturbances, Orthopedic Disorders, Renal Disease and Sepsis. In all cases reviewed, the cause of death appeared to be attributed to the presence of multiple medical problems in addition to their primary reason for hospitalization as well as the patient's advanced age, i.e. the average age of these patients ranged from 75 to 85. These results underscore the need to consider additional factors, when analyzing mortality experience, including but not limited to the patient's severity of illness, general health status, psychological condition and family support. Although this year's model is improved over last year's, we strongly feel these factors should be incorporated by HCFA in any future analysis of mortality rates.

Sibley Memorial Hospital has a well-deserved reputation for providing high quality care and this mortality data does not dispute this. Our nurses and other health professionals provide personalized patient care. The quality of our medical staff is ensured by a comprehensive and rigorous credentialing and

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

reappointment process. We are a full service community hospital and offer a wide range of medical/surgical services. For a community hospital, Sibley treats a large number of cancer patients. In addition we perform a broad range of surgical procedures including a large number of ophthalmologic, orthopedic and neurosurgical procedures.

The HCFA data indicates that a total of 201 Medicare patients admitted to our hospital died within 30 days of admission. It also indicated that 160 died in the hospital and 41 died sometime after discharge. We reviewed this data against our own medical records and found the following discrepancies:

- 2 individuals with identical information about their hospitalization and death were listed, except their names were different. Only one of them was actually a patient. Attachment 1 is the page of the patient listing provided by HCFA with the duplicate crossed out.

- for 9 individuals, HCFA data did not agree with hospital records. For seven of the nine, HCFA did not list the last hospital admission; there was a subsequent admission before death. For two of these nine, the date of death provided by HCFA disagreed with our medical records.

Thus, according to our records 200 Medicare patients who were admitted to Sibley hospital died within 30 days of admission: 164 died in the hospital and 36 died sometime after discharge. Our preliminary research has not been able to determine the cause of death for these 36 cases and therefore we can not comment on them. While the patient outcome for all 200 patients remains the same, these data discrepancies do suggest that there may be additional errors in the data used by HCFA to compute mortality rates. Since we do not have access to all of the data on each patient that was used to determine the predicted mortality rates, it is impossible to verify the accuracy of the diagnostic or other data in your analysis.

Another factor which affects the validity of the mortality rate, and which should be kept in mind when interpreting this data, is the actual number of cases in each diagnostic category upon which the rate is based. The fewer the number of admissions, the less reliable the statistical outcome can be considered. We believe that caution should be used in interpreting mortality rates based on less than 100 cases. Nine of the 16 diagnostic categories had less than 100 cases. In particular, the actual mortality rates for sepsis was based on only 18 cases, renal disease on 11 cases, metabolic/electrolyte disturbances on 37 cases and ophthalmologic diseases on 41 cases.

This type of statistical analysis of mortality is most useful as a screen for triggering additional quality assurance activity. We do not believe that statements about quality of care can be based solely on mortality statistics. Sibley will continue to evaluate the mortality data and incorporate this evaluation into our ongoing quality assurance program. We have a comprehensive quality assurance program which is designed to continually monitor critical elements of all patient services. The results of these monitoring activities are reviewed on an ongoing basis and assist in determining what corrective actions will be taken to improve patient care. The comprehensive quality assurance program assists in maintaining high quality patient care at Sibley Memorial Hospital.

Thank you for the opportunity to review our Medicare mortality data and to comment on it before publication.

Sincerely,

Robert L. Sloan
Chief Executive Officer

DEPARTMENT OF THE AIR FORCE
MALCOLM GROW USAF MEDICAL CENTER (MAC)
ANDREWS AIR FORCE BASE DC 20331-5300

William L. Roper, MD, Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore MD 21207

20 October 1987

Dear Dr. Roper

This morning, I spoke to Mr. Harvey Brook of your organization concerning your letter dated 21 September 1987 regarding selected mortality information on Medicare patients. As I explained to Mr. Brook, Malcolm Grow United States Air Force Medical Center is a Department of Defense hospital and we do not treat Medicare patients. Therefore, we should not be considered in the statistical publication.

According to your data sheet, we show only one Medicare case for 1986. This individual probably was a civilian emergency who was taken to the closest hospital available in the community (i.e., Malcolm Grow Medical Center.) Our mortality rate was 0%. However, I am concerned that if the only Medicare patient brought to this facility were to die, the publication would show a 100% mortality rate for our medical center.

We, therefore, request that you eliminate this military facility from your statistical data base in view of the fact that Medicare patients are rarely treated here. If you have any questions, please feel free to call me at 301-981-3002.

Sincerely

JOHN D. LABASH, Lt Col, USAF, MSC
Associate Administrator

THE WASHINGTON HOSPITAL CENTER

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Room 309 G - Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC

Washington Hospital Center
Hospital = 090011

The mortality statistics on Medicare patients compiled by the Health Care Financing Administration (HCFA) are as important for what they do not tell us as they are for the information they give about health care in our community.

The mortality figures are in some ways a welcome improvement in health statistics reporting. The figures represent an outcome study, evaluating medical care not on procedures but on product, the end results. The numbers further place the "outcome variable" (death) into the context of other risk factors.

What the reader of such a report will always seek to know is:

* Am I getting good medical and surgical care?
* Is the hospital doing a good job?
* Is the hospital better or worse than others?
* Where would I go if I were sick and needed care?

If we consider that low mortality results from good care, then the mortality figures appear to show, at first glance, that the Washington Hospital Center does, indeed, provide "good care," but that is not the whole picture of quality care. These figures simply explore one possible outcome (death) of patients suffering various medical and surgical problems.

Matters of life and death are always confronted in hospital care, but the end result of that care cannot be understood simply by counting the number of patients who die, even if that counting was done with great accuracy. For those who survive their illnesses, and the figures show that they are the vast majority, their quality of life also matters. Do they return to their families free of pain? Are they able to return to work and engage in favorite activities of daily life? Are they able to enjoy their friends, surroundings and themselves?

These qualities are hard to define, let alone measure, but they are at the heart of what we do at the Washington Hospital Center. Survival comes first, but then what? The figures presented by HCFA must by viewed from this perspective. They show only one face of a complex, multi-dimensional picture.

That is why we have problems with what has been presented and how it has been presented.

The HCFA mortality figures are presented in comparison to a range of mortalities which represent the expected death rates for patients of similar ages and with similar related health problems. These numbers attempt to make the mortality figures relevant to each hospital's patient population. They attempt to limit the error which might come from comparing one hospital which cares for the desperately ill with another that takes less complicated cases. Unfortunately, this comparison, like measuring "quality of life," is inexact. Critically, HCFA's methods for measuring expected death rates, have not been proven valid. Indeed, those methods are often flawed.

> For instance, of the 377 deaths reported for the Washington Hospital Center, 49 or eight percent, were reported to have died within 30 days of discharge. The Hospital Center's Quality Assurance department chose to review those cases to assess whether premature discharge from the hospital occurred in any of the cases. The medical records of these patients were reviewed by nurses and physicians. We found that among the 49 patients, seven had actually died in the hospital, not after discharge. And all that were reviewed had been expected to die because of age or comorbidity.
>
> Furthermore, categories of risk have not been well applied by HCFA. For instance, the Hospital Center's Quality Assurance staff determined that in the case of a "low risk" (HCFA classification) 90-year old patient who had been admitted for cataract surgery, and died 24 days following surgery, the patient also had coronary artery disease and history of stroke in the recent past, for which he was being followed and treated. The statistics, as reported, do not take such factors into consideration.
>
> We also found one case where a patient was reported as dying seven days before admission to the hospital.

Clearly, statistics are only as accurate as the observations on which they are based. Inaccurate data yield inaccurate statistics from which inaccurate conclusions are drawn.

We are, therefore, concerned about how the statistics are reported, and how they answer the complex questions we all have about health care. Because of our concerns, we at the Washington Hospital Center believe that simply presenting the mortality figures, even with the "expected ranges," is not enough.

When health care providers present experience and clinical research to the public, we do so only through, or concurrently with, publication in scientific journals. This requires the presentation of the materials and the methodology by which we perform the research and how and why we came to our conclusions about the results. The presentation is scrutinized through peer review before it can be published.

From the current HCFA mortality figures, the authors do not draw ANY conclusions. They present the figures for the education of healthcare providers and consumers. The reader is left to draw his or her own conclusions. But, in order to draw valid and truthful conclusions, the reader, either professional or layman, must have complete access to the methods by which the statistics were derived.

While it appears that HCFA has been conscientious in compiling these figures, the figures themselves may be misleading and are not entirely accurate and balanced. Good health care, not to mention good science, demands more.

The deficiencies in complete and accurate reporting can be remedied. But, the problem of the relationship between mortality figures and good health care and how to measure and analyze other truly important outcome variables (relief of pain, relief of deformity, return to normal function and sense of well being) is far more troublesome. We are hopeful that HCFA's continuing efforts in this direction will help us to maintain and improve quality health care.

For the hospital:

Dunlop Ecker

Dunlop Ecker
President

Harold H. Hawfield M.D.

Harold Hawfield, M.D.
Interim Director, Medical Affairs

For the medical and dental staff:

Paul Corso, MD
Vice Chairman, Medical and Dental Staff
Senior Attending, Cardiac Surgery

co-authored by:

Peter Moskovitz, M.D.
Senior Attending, Orthopaedic Department

Christine Vinh, R.N.
Managing Director, Utilization Review

Florida

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALACHUA GENERAL HOSP-GAINESVILLE FL 32602	FL-19	2768	10	8-14	155	22	18-36	105	35	20-39	44	18	8-33	118	21	15-31	105	34	28-48	53	6	7-31	197	17	13-26
AMI KENDALL REGIONAL MEDIC MIAMI FL 33175	FL-20	1699	11	8-15	98	28	13-33	57	33	17-41	51	12	9-32	79	24	14-33	72	33	28-52	28	25	7-39	104	20	13-30
AMI NORTH RIDGE MEDICAL CE FORT LAUDERDALE FL 33334	FL-21	2972	9	7-13	222	21	16-32	62	15	16-39	35	14	7-35	116	28	16-32	109	37	29-49	23	22	6-41	177	14	12-26
ANNE BATES LEACH EYE HOSP MIAMI FL 33152	FL-22	566	0	0-16	7	0	2-59	.	.		.	.		.	.		.	.		.	.		.	.	
BAPTIST HOSP PENSACOLA FL 32501	FL-23 *	2367	12	9-16	185	22	20-37	81	28	17-37	40	20	8-33	105	27	15-31	86	35	26-47	63	14	10-33	164	17	13-28
BAPTIST HOSP OF MIAMI INC MIAMI FL 33176	FL-24	2687	11	9-15	237	34	21-38	84	21	18-39	88	10	10-30	139	23	17-32	81	42	29-51	41	7	6-32	154	14	15-30
BAPTIST MEDICAL CTR JACKSONVILLE FL 32207	FL-25 *	2528	10	7-14	167	20	16-34	74	22	17-38	51	22	7-30	95	20	15-32	90	36	26-47	57	25	10-35	160	17	11-26
BARTOW MEMORIAL HOSP- INC BARTOW FL 33830	FL-26	329	11	6-15	20	20	6-41	12	50	9-56	13	15	3-45	27	30	9-39	10	50	15-69	14	14	4-45	23	9	5-37
BAY MEDICAL CTR PANAMA CITY FL 32401	FL-27	2370	11	8-15	119	35	18-37	73	26	19-40	40	23	7-33	116	19	14-30	85	38	25-47	36	28	11-41	161	15	12-27
BAYFRONT MEDICAL CENTER SAINT PETERSBURG FL 33701	FL-28 *	2405	14	9-16	248	25	16-31	80	40	20-41	41	20	9-35	107	22	15-32	72	36	29-53	55	24	8-33	125	29	14-31
BAYONET POINT HUDSON REGIO HUDSON FL 33568	FL-29 *	2470	9	8-15	207	19	15-31	89	22	18-38	52	31	10-34	103	17	14-30	105	34	26-46	28	29	16-51	175	14	11-25
BETHESDA MEM HOSP BOYNTON BEACH FL 33435	FL-30	2671	13	9-16	233	21	15-31	114	28	20-38	95	14	8-26	132	36	19-35	111	35	30-50	62	42	14-38	158	22	13-28
BOCA RATON COMMUNITY HOSP-BOCA RATON FL 33432	FL-31 *	5445	11	9-16	579	23	18-31	175	21	22-37	120	18	12-30	277	21	18-30	181	34	32-49	78	27	10-32	363	18	17-29
BRADFORD CO HOSP STARKE FL 32091	FL-32	314	16	8-17	18	61	12-53	11	36	10-60	8	0	1-55	16	31	9-49	8	75	16-76	8	25	1-56	53	15	8-30
BROOKWOOD COMMUNITY HOSP ORLANDO FL 32808	FL-33	919	12	9-16	66	11	13-36	26	38	14-49	24	8	7-40	52	15	12-35	37	57	23-55	33	12	7-36	87	20	11-30
BROWARD GENERAL MED CTR FORT LAUDERDALE FL 33316	FL-34	2708	11	9-15	228	24	17-33	95	26	19-38	65	20	10-32	143	22	15-30	66	36	26-50	60	7	8-31	205	21	15-29
CALHOUN GENERAL HOSP-BLOUNTSTOWN FL 32424	FL-35 *	187	13	9-20	3	67	1-81	10	20	9-61	8	25	2-56	13	23	8-54	6	50	12-78	4	25	1-75	28	21	10-41
CAMPBELLTON GRACEVILLE HOS GRACEVILLE FL 32440	FL-36	272	15	10-20	7	57	8-70	12	25	10-58	4	25	2-74	25	8	11-44	7	43	13-76	10	0	5-55	38	26	10-37
CAPE CANAVERAL HOSP-COCOA BEACH FL 32931	FL-37	1069	9	8-15	102	16	16-37	41	27	16-43	19	21	7-44	49	20	13-37	42	33	22-51	17	12	5-44	74	9	9-28
CAPE CORAL HOSP CAPE CORAL FL 33904	FL-38 *	2626	11	9-15	277	19	17-32	87	25	18-38	64	22	12-35	116	28	16-32	97	48	28-49	46	24	11-38	189	24	14-28
CARROLLWOOD COMMUNITY HOSP TAMPA FL 33614	FL-39 *	594	11	8-16	28	14	9-41	29	21	13-45	19	26	7-44	31	13	9-37	13	62	19-68	20	5	6-43	59	14	9-30
CEDARS MEDICAL CTR INC MIAMI FL 33136	FL-40	2687	11	9-16	218	18	17-33	71	35	21-44	69	19	8-29	117	23	17-33	63	35	29-55	45	18	11-38	206	26	16-30
CENTRAL FL REGIONAL HOSP SANFORD FL 32771	FL-41 *	2425	13	9-15	188	22	16-33	108	34	19-37	79	19	9-29	124	30	19-35	78	42	28-51	66	9	8-30	158	19	10-24
CENTRO ASTURIANO HOSP TAMPA FL 33605	FL-42 *	740	13	9-17	32	22	14-46	25	20	14-49	29	21	6-36	35	20	12-40	21	43	21-62	17	18	5-44	69	23	11-32
CENTRO ESPANOL HOSP TAMPA FL 33603	FL-43 *	535	13	7-15	33	39	14-46	17	29	10-51	4	0	2-74	22	23	9-43	12	42	15-66	7	43	3-62	45	24	10-34
CENTURY MEMORIAL HOSPITAL CENTURY FL 32535	FL-44 *	19	11	1-32	1	100	0-98	1	0	0-97	.	.		3	33	1-81	.	.		.	.		1	0	0-99

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALACHUA GENERAL HOSP- GAINESVILLE FL 32602	33	21	9-45	27	30	17-54	89	10	4-17	138	1	0-6	259	6	2-9	115	6	2-13	13	0	0-100	227	3	3-9	141	1	0-6
AMI KENDALL REGIONAL MEDIC MIAMI FL 33175	11	9	5-56	11	18	14-67	41	7	3-23	11	0	0-100	178	4	3-10	105	3	2-13	10	0	0-95	243	6	2-8	80	1	0-9
AMI NORTH RIDGE MEDICAL CE FOPT LAUDERDALE FL 33334	14	29	9-58	14	14	19-68	34	12	4-27	96	0	0-14	224	4	3-9	113	3	1-12	35	3	0-40	922	4	3-7	158	1	0-6
ANNE BATES LEACH EYE HOSP MIAMI FL 33152	.	.		.	.		.	.		471	0	0-2	.	.		.	.		.	.		3	0	0-94	.	.	
BAPTIST HOSP PENSACOLA FL 32501	36	33	11-46	29	10	20-57	60	13	5-22	14	0	0-99	243	7	3-9	111	9	2-13	25	0	0-65	186	6	2-9	138	4	0-6
BAPTIST HOSP OF MIAMI INC MIAMI FL 33176	17	24	9-54	20	30	18-60	51	6	3-21	9	0	0-100	254	2	3-9	66	2	1-15	10	0	0-100	305	4	2-8	189	2	1-6
BAPTIST MEDICAL CTR JACKSONVILLE FL 32207	33	18	7-42	26	38	18-56	54	9	3-20	21	0	0-91	234	6	3-9	113	6	1-12	28	0	0-85	268	4	3-8	135	1	0-6
BARTOW MEMORIAL HOSP- INC BARTOW FL 33830	4	0	2-76	2	0	3-91	9	22	1-50	.	.		50	2	1-15	17	0	0-41	5	0	0-100	23	0	1-25	17	0	0-66
BAY MEDICAL CTR PANAMA CITY FL 32401	37	24	12-47	39	26	21-53	37	14	2-23	4	25	0-100	243	4	3-9	103	6	2-13	14	0	0-77	312	5	2-8	103	1	0-8
BAYFRONT MEDICAL CENTER SAINT PETERSBURG FL 33701	26	35	9-48	22	45	21-62	96	10	4-17	6	0	0-100	211	7	4-12	71	13	3-18	35	0	0-67	150	9	2-10	130	4	0-7
BAYONET POINT HUDSON REGIO HUDSON FL 33568	18	0	6-49	15	27	21-69	30	3	2-22	3	0	0-100	278	5	3-9	191	2	1-10	32	0	0-75	298	4	2-8	124	0	0-7
BETHESDA MEM HOSP BOYNTON BEACH FL 33435	18	17	7-51	28	36	24-62	112	6	4-17	11	0	0-99	342	7	3-9	167	7	2-11	26	0	0-58	205	5	3-9	165	1	0-6
BOCA RATON COMMUNITY HOSP- BOCA RATON FL 33432	30	10	8-44	46	35	30-61	154	9	5-16	23	0	0-84	564	5	3-9	316	1	1-9	48	0	0-16	524	2	3-7	437	1	1-4
BRADFORD CO HOSP STARKE FL 32091	7	14	3-64	1	0	0-97	3	33	0-81	.	.		51	8	1-15	7	0	1-58	2	0	0-100	19	5	0-30	7	0	0-98
BROOKWOOD COMMUNITY HOSP ORLANDO FL 32808	8	50	10-71	9	44	7-62	21	10	3-33	3	33	0-100	104	5	2-12	54	9	2-19	12	0	0-98	81	4	2-13	53	2	0-13
BROWARD GENERAL MED CTR FORT LAUDERDALE FL 33316	26	19	6-43	24	29	20-59	93	5	4-17	17	6	0-81	213	4	3-10	133	5	3-14	17	0	0-73	283	4	2-8	146	3	1-7
CALHOUN GENERAL HOSP- BLOUNTSTOWN FL 32424	9	0	6-62	1	0	1-97	.	.		.	.		18	6	0-31	9	0	0-54	1	0	0-100	19	0	0-30	2	0	0-98
CAMPBELLTON GRACEVILLE HOS GRACEVILLE FL 32440	8	63	5-64	5	40	12-83	1	0	0-100	.	.		20	5	1-30	15	7	2-39	.	.		31	6	1-21	13	0	0-46
CAPE CANAVERAL HOSP- COCOA BEACH FL 32931	5	20	4-74	10	30	9-62	36	11	3-25	1	0	0-100	133	7	2-11	50	2	0-17	13	0	0-99	106	6	2-10	69	0	0-11
CAPE CORAL HOSP CAPE CORAL FL 33904	5	60	8-78	10	20	11-66	68	10	4-20	1	0	0-100	339	4	2-8	249	2	1-10	22	0	0-94	212	4	2-9	165	1	0-6
CARROLLWOOD COMMUNITY HOSP TAMPA FL 33614	1	100	1-97	18	33	17-61	13	15	2-43	.	.		48	0	1-15	24	0	0-27	11	0	0-97	42	7	1-17	47	0	0-17
CEDARS MEDICAL CTR INC MIAMI FL 33136	12	8	3-53	49	47	27-57	77	10	5-20	15	0	0-86	177	5	3-11	127	11	2-13	17	0	0-45	356	4	3-8	227	1	0-5
CENTRAL FL REGIONAL HOSP SANFORD FL 32771	17	0	7-51	20	35	20-63	64	9	4-20	1	0	0-100	297	5	3-9	148	5	1-11	25	0	0-55	186	5	2-9	142	3	0-6
CENTRO ASTURIANO HOSP TAMPA FL 33605	5	20	2-71	11	27	14-67	27	11	3-28	1	0	0-100	87	5	2-13	61	5	3-19	3	0	0-100	53	9	2-16	33	0	0-24
CENTRO ESPANOL HOSP TAMPA FL 33603	2	0	0-91	3	33	4-85	14	14	2-39	5	0	0-100	70	6	1-13	29	7	0-24	2	0	0-100	60	8	1-14	26	0	0-39
CENTURY MEMORIAL HOSPITAL CENTURY FL 32535	.	.		.	.		.	.		.	.		2	0	0-99	.	.		.	.		2	0	0-99	.	.	

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																													
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease												
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent								
CITRUS MEM HOSP INVERNESS FL 32650	FL-45	2311	12	9-16	217	24	18-34	102	26	21-40	37	19	7-33	114	25	15-31	86	42	28-50	26	27	7-40	188	18	13-26								
CLAY MEMORIAL HOSP GREEN COVE SPRINGS FL 32043	FL-46 *	288	12	7-17	3	33	1-81	9	22	8-62	8	13	1-55	20	20	10-47	8	63	14-74	18	28	4-41	20	30	8-44								
CLEARWATER COMMUNITY HOSP-CLEARWATER FL 33516	FL-47 *	1596	12	7-14	94	20	13-33	58	40	18-42	28	25	10-42	83	31	15-34	59	47	28-53	36	14	6-33	105	21	10-27								
COASTAL COMMUNITIES HOSP BUNNELL FL 32010	FL-48 *	401	12	7-16	28	50	12-46	10	40	7-58	3	33	3-83	31	26	9-37	15	20	15-61	8	13	2-56	54	13	8-30								
CORAL GABLES HOSP CORAL GABLES FL 33134	FL-49	2099	11	10-16	98	24	17-38	63	14	20-44	60	8	8-30	83	17	16-35	103	45	33-53	55	18	11-37	183	20	16-31								
CORAL REEF GENERAL HOSP MIAMI FL 33157	FL-50	1114	14	8-15	49	20	12-38	67	27	18-40	19	11	3-37	51	20	12-35	31	61	24-58	18	28	4-42	117	21	12-28								
DELRAY COMMUNITY HOSPITAL DELRAY BEACH FL 33445	FL-51	2840	11	9-15	193	21	14-31	90	24	18-37	114	14	8-25	146	29	17-32	180	33	31-48	32	28	9-40	214	9	12-26								
DEPOO MEMORIAL DOCTORS HOS KEY WEST FL 33040	FL-52 *	385	15	8-16	27	33	8-40	13	15	12-59	12	17	4-49	17	41	8-47	21	43	18-57	7	14	3-62	28	32	10-41								
DESOTO MEMORIAL HOSP ARCADIA FL 33821	FL-53	509	12	9-18	24	46	11-46	19	21	10-48	19	11	5-41	28	11	10-40	35	43	21-53	14	14	8-52	66	11	10-31								
DOCTORS GENERAL HOSP PLANTATION FL 33313	FL-54 *	1010	16	9-16	63	16	12-36	42	33	16-44	28	14	6-36	34	26	11-39	26	38	22-58	26	50	10-45	56	30	11-33								
DOCTORS HOSP CORAL GABLES FL 33134	FL-55	1886	10	9-16	158	20	17-35	55	24	19-44	38	8	9-37	70	17	15-36	64	38	31-56	25	20	8-42	182	13	14-28								
DOCTORS HOSP OF HOLLYWOOD HOLLYWOOD FL 33022	FL-56 *	871	15	10-17	43	16	8-34	27	26	15-49	34	18	9-38	60	28	18-41	35	49	26-59	27	15	6-38	71	21	13-34								
DOCTORS HOSP OF LAKE WORTH LAKE WORTH FL 33460	FL-57 *	1629	13	10-17	118	20	12-31	78	35	20-41	39	15	9-35	110	22	17-34	73	49	30-53	39	10	9-37	123	24	16-33								
DOCTORS HOSP OF SARASOTA I SARASOTA FL 33579	FL-58 *	1876	10	9-15	137	15	15-33	72	28	19-41	31	13	11-41	119	24	17-33	59	36	29-54	34	24	12-43	143	20	13-29								
DOCTORS MEMORIAL HOSP BONIFAY FL 32425	FL-59	299	12	10-20	7	71	9-70	11	18	10-61	4	25	2-74	36	17	11-39	14	36	20-68	9	22	4-57	64	16	11-32								
DOCTORS MEMORIAL HOSP-PERRY FL 32347	FL-60	270	17	10-20	10	40	8-61	6	67	6-70	6	33	3-64	14	21	7-49	19	21	21-64	7	43	4-64	46	30	10-35								
EAST PASCO MEDICAL CTR ZEPHYRHILLS FL 33599	FL-61 *	1285	12	9-16	70	21	11-34	53	42	17-41	33	9	6-34	66	26	14-35	85	39	27-49	23	9	6-40	117	18	13-30								
EAST POINTE HOSP LEHIGH ACRES FL 33936	FL-62	955	11	9-16	90	20	14-34	36	19	16-46	18	6	6-44	55	31	14-37	33	42	24-57	7	0	2-59	84	19	12-31								
ED FRASER MEMORIAL HOSP MACCLENNY FL 32063	FL-63 *	175	10	6-17	4	75	4-78	2	0	2-89	2	0	0-90	7	0	4-63	1	0	1-97	3	33	8-90	30	10	5-33								
EDWARD H WHITE MEMORIAL HO SAINT PETERSBURG FL 33713	FL-64 *	1421	11	8-15	127	13	15-34	43	42	16-44	39	15	10-37	55	27	16-39	49	39	28-56	35	20	7-36	80	23	10-28								
ENGLEWOOD COMMUNITY HOSP ENGLEWOOD FL 33533	FL-65 *	1063	10	9-16	76	26	17-39	39	21	15-44	18	17	4-41	58	24	13-35	65	29	25-49	35	14	9-38	97	9	12-30								
EVERGLADES MEMORIAL HOSP PAHOKEE FL 33476	FL-66 *	137	12	8-21	6	67	3-65	2	50	1-89	3	0	1-81	13	8	6-50	4	50	7-82	10	10	4-54	20	15	8-45								
FAWCETT MEM HOSP PORT CHARLOTTE FL 33952	FL-67	2394	9	8-14	169	21	14-31	105	24	20-38	60	12	7-28	136	18	15-30	75	39	28-51	32	9	6-36	160	9	11-26								
FISH MEMORIAL HOSP NEW SMYRNA BEACH FL 32069	FL-68 *	1095	12	8-15	75	15	10-31	72	29	18-39	26	8	3-32	75	28	13-33	47	45	25-53	19	21	4-40	79	10	9-27								
FISH MEMORIAL HOSPITAL DELAND FL 32720	FL-69	1441	12	10-17	109	17	14-34	63	27	18-41	47	13	9-34	63	27	15-36	58	47	27-53	50	14	7-31	174	21	14-28								
FISHERMEN'S HOSP INC MARATHON FL 33050	FL-70 *	402	13	7-15	29	28	11-43	18	17	10-50	14	21	5-47	17	29	6-44	17	71	16-60	7	14	1-59	32	19	6-33								

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CITRUS MEM HOSP INVERNESS FL 32650	9	22	5-61	22	32	19-60	48	13	2-20	2	0	0-100	300	8	4-10	150	6	2-12	36	0	0-87	215	1	2-9	92	0	0-8
CLAY MEMORIAL HOSP GREEN COVE SPRINGS FL 32043	1	0	0-100	* 5	20	7-77	8	13	1-53	.	.		40	8	2-19	9	0	1-50	2	0	0-100	47	0	1-17	6	0	0-97
CLEARWATER COMMUNITY HOSP-CLEARWATER FL 33516	5	60	10-81	11	45	12-65	62	10	4-20	1	0	0-100	152	7	2-10	33	3	1-22	5	0	0-100	122	5	2-11	337	1	0-4
COASTAL COMMUNITIES HOSP BUNNELL FL 32010	3	67	5-86	3	33	3-83	5	0	0-78	.	.		60	3	1-14	20	0	0-31	1	0	0-100	36	0	1-18	9	0	0-94
CORAL GABLES HOSP CORAL GABLES FL 33134	15	13	10-57	28	36	21-58	36	3	3-25	2	0	0-100	235	2	3-10	147	4	3-13	19	0	0-80	144	3	2-10	127	1	0-7
CORAL REEF GENERAL HOSP MIAMI FL 33157	17	53	14-61	16	63	18-64	34	21	3-25	3	0	0-100	89	6	1-12	42	5	1-19	1	0	0-100	87	6	1-11	60	5	0-12
DELRAY COMMUNITY HOSPITAL DELRAY BEACH FL 33445	18	33	13-58	21	43	22-64	57	14	3-20	20	0	0-88	255	2	2-8	175	2	1-10	14	0	0-94	367	3	3-7	98	2	0-8
DEPOO MEMORIAL DOCTORS HOS KEY WEST FL 33040	2	100	1-90	8	0	9-68	18	11	1-32	1	0	0-100	46	7	1-16	23	4	0-28	5	0	0-100	21	5	0-28	28	4	0-31
DESOTO MEMORIAL HOSP ARCADIA FL 33821	10	0	5-58	7	14	5-65	2	0	0-93	.	.		44	5	2-18	20	5	1-30	3	0	0-100	63	8	1-14	7	0	0-95
DOCTORS GENERAL HOSP PLANTATION FL 33313	13	46	13-65	9	56	10-66	35	11	3-25	1	0	0-100	80	6	2-14	72	11	3-17	7	0	0-100	78	9	2-13	82	2	0-9
DOCTORS HOSP CORAL GABLES FL 33134	17	6	8-53	17	29	19-64	70	9	4-19	11	0	0-98	194	3	3-10	102	1	1-13	16	0	0-88	151	5	3-12	129	3	1-7
DOCTORS HOSP OF HOLLYWOOD HOLLYWOOD FL 33022	9	44	7-64	13	62	20-70	23	9	2-29	7	0	0-100	48	8	2-17	46	11	2-20	2	0	0-100	123	6	2-10	77	0	0-10
DOCTORS HOSP OF LAKE WORTH LAKE WORTH FL 33460	12	33	7-58	23	13	20-60	63	8	4-20	14	0	0-99	168	5	2-10	79	0	1-14	14	0	0-91	157	5	3-10	67	0	0-11
DOCTORS HOSP OF SARASOTA I SARASOTA FL 33579	15	27	13-61	14	21	17-66	49	8	3-20	80	0	0-14	170	4	2-10	109	3	1-12	35	0	0-68	171	2	2-9	130	1	0-6
DOCTORS MEMORIAL HOSP BONIFAY FL 32425		.		2	50	3-91	.	.		.	.		18	6	1-32	6	0	0-70	2	0	0-100	50	0	1-15	2	50	0-100
DOCTORS MEMORIAL HOSP-PERRY FL 32347	2	0	0-91	16	25	12-56	1	0	0-99	.	.		20	5	0-30	6	0	0-72	1	0	0-100	35	0	1-19	3	0	0-100
EAST PASCO MEDICAL CTR ZEPHYRHILLS FL 33599	6	17	3-68	12	42	16-67	37	8	3-24	3	0	0-100	145	5	2-11	87	3	1-13	12	0	0-100	138	3	2-9	68	3	0-11
EAST POINTE HOSP LEHIGH ACRES FL 33936	4	50	1-76	9	22	8-64	17	6	2-35	2	0	0-100	102	2	2-12	59	3	1-16	7	0	0-100	96	7	1-11	53	4	0-14
ED FRASER MEMORIAL HOSP MACCLENNY FL 32063	9	22	8-65	1	100	2-98	.	.		.	.		17	6	0-33	2	0	1-89	.	.		24	0	0-25	1	0	0-100
EDWARD H WHITE MEMORIAL HO SAINT PETERSBURG FL 33713	9	22	15-74	12	0	15-66	70	10	4-19	7	0	0-100	148	5	3-12	96	2	2-13	27	0	0-48	67	0	2-14	159	3	0-6
ENGLEWOOD COMMUNITY HOSP ENGLEWOOD FL 33533	5	0	5-75	7	29	12-75	23	4	2-30	1	0	0-100	151	4	2-10	52	4	1-17	4	0	0-100	130	2	2-10	44	0	0-15
EVERGLADES MEMORIAL HOSP PAHOKEE FL 33476	3	33	4-85	2	0	2-90	.	.		.	.		14	0	0-43	4	0	0-80	1	0	0-100	9	11	0-50	2	0	0-100
FAWCETT MEM HOSP PORT CHARLOTTE FL 33952	13	62	13-65	24	17	16-55	47	11	4-23	10	0	0-79	263	5	3-10	127	3	1-11	24	0	0-58	246	3	2-8	212	2	0-5
FISH MEMORIAL HOSP NEW SMYRNA BEACH FL 32069	7	29	3-65	14	36	16-64	44	16	4-23	.	.		125	6	2-12	102	0	1-12	8	0	0-100	62	2	1-14	78	1	0-9
FISH MEMORIAL HOSPITAL DELAND FL 32720	20	30	10-53	13	23	16-66	43	9	4-24	4	0	0-100	169	3	2-10	118	1	1-12	9	0	0-100	164	5	2-9	32	6	0-19
FISHERMEN'S HOSP INC MARATHON FL 33050	1	100	0-97	1	100	1-97	8	0	1-53	2	0	0-100	49	2	1-17	41	5	1-19	5	0	0-100	26	8	0-23	18	0	0-50

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
FL MEDICAL CTR FORT LAUDERDALE FL 33313	FL-71	4334	11	9-15	307	22	19-34	119	26	20-38	91	12	8-27	229	25	19-31	188	38	31-47	67	16	10-33	235	17	15-29
FLAGLER HOSP SAINT AUGUSTINE FL 32084	FL-72 *	1010	13	8-16	79	27	16-39	39	36	14-42	22	14	4-36	44	25	12-36	48	40	25-53	11	27	9-59	89	22	11-29
FLORIDA HOSP ORLANDO FL 32803	FL-73	8402	10	8-14	521	25	18-32	217	29	22-36	120	14	11-29	355	28	18-28	391	31	30-42	136	16	9-28	490	20	12-23
FLORIDA KEYS MEM HOSP KEY WEST FL 33040	FL-74	281	16	8-18	18	50	11-52	11	0	11-62	12	25	2-46	25	28	9-41	10	20	14-68	5	0	2-69	28	36	7-37
GADSDEN MEMORIAL HOSP- QUINCY FL 32351	FL-75	332	13	9-18	9	67	9-64	21	29	14-52	17	12	4-41	34	12	9-37	3	67	7-88	17	6	5-43	53	23	10-33
GEORGE E WEEMS MEMORIAL HO APALACHICOLA FL 32320	FL-76 *	22	14	1-28	1	100	0-99	.	.		1	100	0-97	.	.		.	.		1	0	0-99	.		
GEORGE E WEEMS MEMORIAL HO APALACHICOLA FL 32320	FL-77 *	43	12	4-24	2	50	1-89	.	.		.	.		2	50	2-89	.	.		2	0	0-90	6	17	4-66
GLADES GENERAL HOSP- BELLE GLADE FL 33430	FL-78 *	190	11	7-18	8	38	9-68	4	0	3-76	1	0	0-100	11	27	5-52	5	40	8-78	13	15	7-53	19	16	5-40
GOOD SAMARITAN HOSPITAL WEST PALM BEACH FL 33402	FL-79	2049	13	10-16	224	23	15-31	84	25	19-39	32	28	9-39	92	29	15-33	87	39	28-50	39	23	8-36	155	12	12-27
GULF BREEZE HOSP GULF BREEZE FL 32561	FL-80 *	195	7	6-16	9	33	5-58	3	0	2-82	5	0	0-69	8	0	3-57	8	38	17-77	3	33	3-83	24	0	5-37
GULF PINES HOSP PORT SAINT JOE FL 32456	FL-81 *	126	13	7-20	5	60	4-71	2	0	1-89	2	0	1-89	9	33	4-55	9	33	16-73	9	0	2-53	19	11	5-40
H LEE MOFFITT CANCER CTR & TAMPA FL 33612	FL-82 *	52	10	11-33	31	16	12-45	.	.		.	.		.	.		.	.		.	.		1	0	1-98
HALIFAX HOSPITAL MEDICAL C DAYTONA BEACH FL 32014	FL-83	3914	11	9-15	450	20	17-31	136	30	21-37	62	18	7-28	182	23	17-31	124	42	29-48	87	9	8-29	214	14	14-27
HAMILTON CO MEM HOSP JASPER FL 32052	FL-84 *	185	12	7-18	8	50	3-57	5	20	4-72	3	0	1-81	6	0	3-64	6	33	11-77	7	0	2-60	40	15	7-31
HARBORSIDE HOSP SAINT PETERSBURG FL 33705	FL-85 *	344	8	5-14	7	29	6-66	7	29	6-66	3	0	1-81	16	19	9-50	7	57	16-79	9	0	4-56	21	38	6-40
HARDEE MEMORIAL HOSP WAUCHULA FL 33873	FL-86 *	305	15	9-19	8	75	12-72	14	36	13-59	3	0	0-84	17	29	8-47	8	88	18-78	28	18	7-39	56	20	10-31
HCA GULF COAST HOSP PANAMA CITY FL 32405	FL-87 *	1487	11	8-14	114	32	18-38	47	34	16-42	32	6	6-35	60	23	14-37	33	48	20-53	30	13	5-35	87	18	9-27
HCA MEDICAL CENTER OF PORT PORT ST LUCIE FL 34952	FL-88	1539	9	8-15	109	21	15-34	59	19	18-42	35	14	8-36	73	18	15-35	78	35	24-46	20	10	12-52	97	16	12-30
HCA NEW PORT RICHEY HOSP NEW PORT RICHEY FL 33552	FL-89 *	4985	12	9-15	474	21	16-30	176	27	20-35	142	18	14-31	283	27	17-29	198	48	31-47	75	16	13-36	318	17	14-26
HCA NORTH FLORIDA REGIONAL GAINESVILLE FL 32602	FL-90 *	3497	9	7-14	255	25	19-34	103	31	19-37	45	24	8-33	140	22	17-32	100	30	28-49	34	6	6-34	195	14	12-25
HCA NORTH OKALOOSA MEDICAL CRESTVIEW FL 32536	FL-91	696	9	8-16	22	18	8-44	14	7	10-55	11	9	2-48	36	25	12-40	29	28	23-58	25	0	7-40	86	16	12-30
HCA OAK HILL HOSPITAL SPRING HILL FL 33526	FL-92 *	1549	11	8-15	130	17	16-35	40	33	15-42	25	16	7-40	50	28	13-37	95	33	27-48	31	45	12-44	125	18	11-26
HCA RAULERSON HOSPITAL OKEECHOBEE FL 33472	FL-93 *	1066	10	9-16	34	21	14-45	43	23	15-42	34	15	8-36	86	16	13-32	49	29	24-52	28	11	6-36	143	12	11-26
HCA SUN CITY HOSP SUN CITY CENTER FL 33570	FL-94 *	1201	10	8-15	92	18	14-34	46	33	14-40	25	12	6-38	61	20	11-32	38	45	23-54	15	33	9-53	119	12	12-29
HCA TWIN CITIES HOSP NICEVILLE FL 32578	FL-95 *	354	10	9-18	19	21	8-46	9	11	10-66	13	8	5-48	12	17	7-53	21	29	20-60	14	14	6-50	33	12	10-39
HCA UNIVERSITY HOSP TAMARAC FL 33321	FL-96 *	2762	11	9-15	275	23	18-33	97	20	19-37	68	21	8-29	123	28	16-32	136	32	31-49	33	18	8-38	160	18	12-27

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
FL MEDICAL CTR FORT LAUDERDALE FL 33313	25	32	10-50	45	38	31-62	55	9	5-24	38	0	0-39	303	3	3-10	199	7	3-12	27	0	0-51	924	4	3-7	180	1	0-5
FLAGLER HOSP SAINT AUGUSTINE FL 32084	17	41	7-52	12	17	17-69	14	0	3-42	7	0	0-100	93	3	2-12	74	3	1-14	12	0	0-100	75	7	1-12	53	0	0-14
FLORIDA HOSP ORLANDO FL 32803	74	20	11-40	62	45	25-52	172	8	5-16	73	0	0-16	712	6	4-9	322	4	2-10	57	0	0-24	1595	5	3-6	522	2	1-4
FLORIDA KEYS MEM HOSP KEY WEST FL 33040	1	100	1-97	1	100	2-98	12	0	1-42	.	.		24	0	1-25	11	18	0-48		.		18	6	0-31	11	0	0-83
GADSDEN MEMORIAL HOSP- QUINCY FL 32351	6	33	5-71	4	0	6-80	.	.		.	.		38	0	1-18	5	0	0-77	1	100	0-100	20	5	0-29	4	0	0-100
GEORGE E WEEMS MEMORIAL HO APALACHICOLA FL 32320	.	.		.	.		.	.		.	.		3	0	0-95	.	.		.	.		6	17	0-70	.	.	
GEORGE E WEEMS MEMORIAL HO APALACHICOLA FL 32320	.	.		.	.		.	.		.	.		4	0	0-84	2	0	0-96	1	0	0-100	[illegible]	0	0-75	2	0	0-100
GLADES GENERAL HOSP- BELLE GLADE FL 33430	3	0	0-83	5	[illegible]0	7-76	2	0	0-97	.	.		18	0	2-33	19	0	0-38	.	.		22	0	1-26	1	0	0-100
GOOD SAMARITAN HOSPITAL WEST PALM BEACH FL 33402	10	30	12-69	25	44	23-62	74	7	3-17	12	0	0-99	234	9	3-10	105	5	1-12	19	5	0-99	120	4	2-11	139	1	0-6
GULF BREEZE HOSP GULF BREEZE FL 32561	2	50	0-94	1	0	2-98	6	0	0-67	.	.		19	5	0-30	5	0	0-73	4	0	0-100	20	0	0-28	13	0	0-86
GULF PINES HOSP PORT SAINT JOE FL 32456	.	.		[illegible]	100	1-97	.	.		.	.		15	0	0-36	3	0	0-91	1	0	0-100	21	5	1-27	1	0	0-100
H LEE MOFFITT CANCER CTR & TAMPA FL 33612	.	.		.	.		.	.		.	.		1	0	0-100	2	0	0-90	1	0	0-100	.	.		.	.	
HALIFAX HOSPITAL MEDICAL C DAYTONA BEACH FL 32014	33	45	13-49	65	25	26-53	134	4	4-15	18	0	0-81	331	5	3-9	173	5	2-11	35	0	0-77	221	3	2-8	370	1	0-4
HAMILTON CO MEM HOSP JASPER FL 32052	2	0	5-93	4	50	8-83	8	0	0-57	.	.		18	11	1-31	7	0	0-62	1	0	0-100	11	9	0-46	8	0	0-78
HARBORSIDE HOSP SAINT PETERSBURG FL 33705	1	0	1-97	3	33	5-86	8	13	1-53	6	[illegible]	0-100	29	7	1-22	11	18	1-44	1	0	0-100	24	0	0-25	24	0	0-41
HARDEE MEMORIAL HOSP WAUCHULA FL 33873	3	0	2-82	4	0	9-85	2	0	0-95	1	0	0-100	24	13	1-26	11	0	1-44	.	.		23	13	1-26	14	0	0-53
HCA GULF COAST HOSP PANAMA CITY FL 32405	22	23	6-46	37	35	21-54	39	8	3-23	15	7	0-91	187	5	3-10	118	5	2-12	17	0	0-72	111	4	1-10	120	[illegible]	0-7
HCA MEDICAL CENTER OF PORT PORT ST LUCIE FL 34952	3	0	3-84	15	33	17-65	39	3	3-25	3	0	0-100	169	4	2-10	96	1	2-13	9	0	0-98	228	2	2-8	120	2	0-7
HCA NEW PORT RICHEY HOSP NEW PORT RICHEY FL 33552	26	19	10-50	37	41	26-59	107	[illegible]	4-16	3	0	0-100	478	5	3-9	420	2	2-9	55	0	0-25	588	5	3-7	259	[illegible]	0-4
HCA NORTH FLORIDA REGIONAL GAINESVILLE FL 32602	31	19	13-50	16	19	20-67	62	6	5-22	23	0	0-40	341	4	3-9	114	4	1-12	32	0	0-53	472	6	3-7	384	1	0-4
HCA NORTH OKALOOSA MEDICAL CRESTVIEW FL 32536	15	20	6-53	16	56	20-67	19	11	1-31	.	.		49	2	1-15	41	0	1-19	5	0	0-99	128	1	1-9	21	5	0-44
HCA OAK HILL HOSPITAL SPRING HILL FL 33526	[illegible]	0	3-67	13	31	22-73	28	11	3-28	.	.		227	4	2-9	129	5	1-11	7	0	0-100	178	1	2-8	65	5	0-11
HCA RAULERSON HOSPITAL OKEECHOBEE FL 33472	5	20	3-72	7	71	10-73	[illegible]	0	0-65	7	0	0-100	142	6	2-11	61	5	2-16	1	0	0-100	148	1	2-10	22	0	0-29
HCA SUN CITY HOSP SUN CITY CENTER FL 33570	5	20	2-71	13	38	12-62	19	11	2-33	1	0	0-100	163	3	3-11	58	2	1-16	8	0	0-100	156	1	2-10	78	0	0-9
HCA TWIN CITIES HOSP NICEVILLE FL 32578	6	0	1-66	6	33	12-79	6	17	1-62	.	.		46	7	2-18	26	0	0-26	7	0	0-88	35	[illegible]	1-20	15	0	0-59
HCA UNIVERSITY HOSP TAMARAC FL 33321	17	24	7-52	21	29	21-63	63	6	4-21	5	[illegible]	0-100	287	5	2-9	215	5	2-10	34	3	0-57	265	3	2-8	154	1	0-6

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HEART OF FLORIDA HOSP HAINES CITY FL 33844	FL-97 *	468	12	8-16	38	18	9-37	18	28	10-50	10	10	2-50	25	20	9-41	31	39	23-57	20	0	4-39	49	16	7-29
HENDRY GENERAL HOSP- CLEWISTON FL 33440	FL-98	276	11	7-17	11	64	9-60	17	35	10-51	2	0	3-91	20	35	9-45	[illegible]	38	11-69	10	0	2-50	26	[illegible]	8-40
HIALEAH HOSP HIALEAH FL 33013	FL-99 *	1299	13	9-16	82	33	16-37	43	28	15-42	34	21	8-37	57	26	14-36	66	36	28-52	17	24	7-47	101	12	11-28
HIGHLANDS REGIONAL MEDICAL SEBRING FL 33870	FL-100*	1586	13	9-16	114	18	14-34	58	34	18-42	28	18	9-40	83	25	15-34	71	41	28-52	45	11	8-34	153	24	13-28
HILLSBOROUGH CO HOSP- TAMPA FL 33680	FL-101*	229	3	3-12	4	25	6-81	3	0	2-81	.	.		2	50	5-94	.	.		3	[illegible]	0-83	4	0	4-77
HOLLYWOOD MEDICAL CENTER I HOLLYWOOD FL 33021	FL-102	1984	13	10-16	186	15	15-32	54	19	19-44	35	11	7-34	98	31	17-35	88	41	30-52	21	19	6-42	152	27	15-31
HOLMES REGIONAL MEDICAL CE MELBOURNE FL 32901	FL-103	4814	10	8-15	438	20	17-31	195	20	20-35	109	12	8-26	209	24	17-30	190	36	30-46	46	13	9-36	300	18	13-25
HOLY CROSS HOSP FORT LAUDERDALE FL 33308	FL-104*	4673	11	9-15	414	23	18-33	142	29	23-40	81	19	12-33	191	26	19-32	161	34	31-49	62	24	12-36	302	25	16-28
HUMAN HOSP DESTIN DESTIN FL 32541	FL-105	35	9	4-27	2	50	0-92	1	0	0-97	1	0	0-98	2	50	2-90	.	.		1	0	0-98	5	0	2-69
HUMANA HOSP BENNETT PLANTATION FL 33324	FL-106	2125	11	8-15	158	21	17-34	75	25	19-40	68	19	8-29	70	33	15-35	95	33	29-50	36	36	11-41	124	23	13-29
HUMANA HOSP BISCAYNE MIAMI FL 33180	FL-107	3013	12	10-17	169	20	13-30	100	27	20-39	71	1	7-27	153	20	19-34	210	38	34-50	43	14	8-35	214	19	17-31
HUMANA HOSP BRANDON BRANDON FL 33511	FL-108*	1613	11	8-14	99	11	9-28	78	24	17-38	37	19	7-34	65	11	12-33	54	44	22-48	40	25	7-34	164	23	13-27
HUMANA HOSP CYPRESS HOSP POMPANO BEACH FL 33060	FL-109*	1456	12	10-17	102	26	18-38	40	30	18-47	34	24	6-34	70	26	17-38	75	36	31-54	30	10	7-38	132	20	16-33
HUMANA HOSP DAYTONA DAYTONA BEACH FL 32020	FL-110	1320	9	8-15	112	26	15-34	35	26	15-45	24	25	9-44	49	14	12-36	37	32	26-58	19	11	5-42	145	14	12-26
HUMANA HOSP KISSIMMEE KISSIMMEE FL 32741	FL-111*	1513	10	8-15	100	19	15-35	45	38	17-44	31	13	6-35	71	21	14-34	46	43	26-55	50	10	7-31	151	16	13-27
HUMANA HOSP LUCERNE ORLANDO FL 32801	FL-112*	2339	8	6-13	115	19	14-33	34	15	15-46	37	16	9-37	95	21	15-32	86	34	25-46	50	14	6-30	106	21	12-29
HUMANA HOSP NORTHSIDE SAINT PETERSBURG FL 33709	FL-113	1455	17	9-16	72	28	17-40	43	35	18-46	36	25	6-33	91	41	16-34	57	51	24-50	35	34	8-38	128	25	15-32
HUMANA HOSP OF FORT WALTON FORT WALTON BEACH FL 32548	FL-114	1327	11	7-14	79	20	12-33	46	22	17-44	28	18	4-33	46	15	12-37	41	34	22-52	23	17	6-40	124	25	13-29
HUMANA HOSP OF SOUTH BROWA HOLLYWOOD FL 33023	FL-115	574	12	8-16	49	20	11-37	13	15	10-56	18	22	6-44	30	23	13-45	25	52	20-57	15	40	5-46	45	11	7-30
HUMANA HOSP ORANGE PARK ORANGE PARK FL 32073	FL-116	1348	9	8-15	92	21	13-34	39	31	14-42	24	4	4-36	71	18	13-34	41	37	25-55	36	19	6-34	130	11	12-27
HUMANA HOSP PALM BEACHES WEST PALM BEACH FL 33407	FL-117*	1438	13	10-17	93	23	14-35	50	26	19-46	38	8	8-35	80	18	14-33	67	37	28-52	48	33	10-37	124	21	17-33
HUMANA HOSP PASCO DADE CITY FL 33525	FL-118*	901	14	8-15	64	23	14-37	22	41	11-47	16	0	3-40	60	30	14-35	35	40	22-55	25	16	5-38	103	27	11-28
HUMANA HOSP SEBASTIAN SEBASTIAN FL 32958	FL-119	1246	8	8-15	87	18	16-37	50	20	18-44	23	22	8-42	41	24	12-38	69	22	25-49	11	9	4-51	80	16	11-30
HUMANA HOSP ST PETERSBURG SAINT PETERSBURG FL 33710	FL-120	2489	12	9-15	171	21	17-34	81	35	19-40	77	18	9-29	139	29	17-33	92	45	27-48	38	21	10-38	170	24	16-30
HUMANA HOSP SUN BAY SAINT PETERSBURG FL 33705	FL-121	1287	17	11-18	70	29	14-37	51	41	21-47	45	20	8-33	54	41	14-37	44	48	27-57	43	35	9-36	125	26	15-32 3
HUMANA WOMENS HOSP TAMPA TAMPA FL 33607	FL-122*	89	2	2-14	17	12	6-45				.	.		.	.		.	.		.			.	.	

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HEART OF FLORIDA HOSP HAINES CITY FL 33844	6	33	4-69	3	0	6-88	18	22	1-33	1	0	0-100	60	0	1-14	36	0	1-21	1	0	0-100	36	0	1-19	13	0	0-83
HENDRY GENERAL HOSP CLEWISTON FL 33440	5	0	1-71	7	0	6-66	.	.		.	.		29	0	0-22	13	0	1-40	.	.		40	3	1-17	14	0	0-78
HIALEAH HOSP HIALEAH FL 33013	21	29	9-50	17	41	18-63	26	19	2-28	2	0	0-100	120	3	2-12	74	7	2-16	11	0	0-100	151	4	2-9	35	6	0-19
HIGHLANDS REGIONAL MEDICAL SEBRING FL 33870	19	16	10-53	12	58	16-68	39	5	3-24	.	.		164	9	3-11	103	4	1-12	26	12	0-67	202	2	2-9	57	7	0-12
HILLSBOROUGH CO HOSP-TAMPA FL 33680	2	50	6-94	3	67	6-87	.	.		.	.		3	33	0-95	2	0	4-92	.	.		4	0	0-92	3	0	0-100
HOLLYWOOD MEDICAL CENTER I HOLLYWOOD FL 33021	14	50	9-57	33	33	21-56	49	10	4-24	2	0	0-100	202	12	3-11	147	8	2-12	20	0	0-66	243	3	3-9	121	3	0-7
HOLMES REGIONAL MEDICAL CE MELBOURNE FL 32901	56	18	9-40	42	36	23-55	120	8	4-17	32	0	0-62	553	3	3-8	305	3	2-10	38	0	0-82	480	5	3-7	357	1	1-4
HOLY CROSS HOSP FORT LAUDERDALE FL 33308	32	22	17-55	29	21	23-60	114	11	5-18	13	0	0-89	455	5	4-9	188	4	2-11	26	0	0-61	576	4	3-7	457	2	1-4
HUMAN HOSP DESTIN DESTIN FL 32541	1	0	0-99	1	0	0-97	.	.		.	.		7	0	1-57	.	.		.	.		.	.		5	0	0-77
HUMANA HOSP BENNETT PLANTATION FL 33324	18	22	5-48	15	53	23-72	53	11	3-20	35	0	0-40	225	3	2-9	142	4	1-11	18	0	0-83	245	2	2-8	126	1	0-7
HUMANA HOSP BISCAYNE MIAMI FL 33180	20	40	11-54	20	30	17-59	72	4	4-19	13	0	0-86	229	5	3-10	107	5	2-14	7	0	0-100	444	3	3-8	118	3	0-7
HUMANA HOSP BRANDON BRANDON FL 33511	16	25	7-52	16	38	16-62	55	9	4-21	10	0	0-100	154	4	2-10	73	4	1-14	14	0	0-99	150	3	1-8	113	0	0-7
HUMANA HOSP CYPRESS HOSP POMPANO BEACH FL 33060	25	20	17-58	14	29	16-65	49	8	4-22	15	0	0-88	137	5	3-12	89	4	1-13	14	0	0-72	153	4	2-10	83	4	0-9
HUMANA HOSP DAYTONA DAYTONA BEACH FL 32020	7	0	5-67	10	40	11-65	31	3	2-25	.	.		143	3	2-10	78	0	1-14	11	0	0-100	100	3	2-11	64	0	0-11
HUMANA HOSP KISSIMMEE KISSIMMEE FL 32741	14	64	15-65	17	53	19-64	24	8	3-30	2	0	0-100	164	5	2-10	88	5	1-14	15	0	0-88	204	2	2-8	98	0	0-8
HUMANA HOSP LUCERNE ORLANDO FL 32801	21	24	11-53	8	25	12-72	28	4	3-29	91	1	0-11	196	5	3-10	99	4	1-12	25	0	0-67	562	3	3-7	145	2	0-6
HUMANA HOSP NORTHSIDE SAINT PETERSBURG FL 33709	17	47	12-58	28	64	23-60	53	17	3-21	32	0	0-78	121	5	2-11	69	10	2-16	7	0	0-87	121	5	2-10	78	1	0-9
HUMANA HOSP OF FORT WALTON FORT WALTON BEACH FL 32548	17	12	6-50	14	29	15-63	42	19	3-24	5	0	0-100	116	9	2-12	74	5	1-14	19	0	0-88	123	3	2-10	90	*2	0-8
HUMANA HOSP OF SOUTH BROWA HOLLYWOOD FL 33023	4	0	15-91	5	20	4-73	17	6	2-35	.	.		54	6	2-16	21	5	1-29	2	0	0-100	61	2	1-14	33	0	0-23
HUMANA HOSP ORANGE PARK ORANGE PARK FL 32073	13	31	9-59	12	25	14-65	38	5	3-25	3	0	0-100	130	5	2-11	90	2	2-14	9	0	0-95	152	3	2-9	85	4	0-9
HUMANA HOSP PALM BEACHES WEST PALM BEACH FL 33407	10	30	7-62	20	35	19-61	36	11	3-25	4	0	0-100	140	4	3-11	64	11	1-16	6	0	0-87	172	5	2-10	64	0	0-11
HUMANA HOSP PASCO DADE CITY FL 33525	6	33	2-67	9	33	12-69	18	6	1-32	.	.		98	7	2-12	73	4	1-15	10	0	0-67	83	7	2-12	48	0	0-16
HUMANA HOSP SEBASTIAN SEBASTIAN FL 32958	5	20	3-72	4	25	4-79	12	0	1-42	.	.		120	2	3-12	67	4	1-15	3	0	0-100	211	4	2-8	52	2	0-13
HUMANA HOSP ST PETERSBURG SAINT PETERSBURG FL 33710	30	30	12-50	18	28	18-62	85	8	4-17	4	0	0-100	262	5	3-10	151	5	2-12	37	0	0-27	187	2	3-9	119	3	0-7
HUMANA HOSP SUN BAY SAINT PETERSBURG FL 33705	14	43	9-57	37	30	21-54	53	11	4-23	4	0	0-100	133	6	2-11	78	4	2-16	12	0	0-44	56	9	2-15	60	3	0-12
HUMANA WOMENS HOSP TAMPA TAMPA FL 33607	.	.		.	.		.	.		.	.		2	0	0-99	1	0	0-100	47	0	0-27	.	.		.	.	

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
IMPERIAL POINT MEDICAL CEN FORT LAUDERDALE FL 33308	FL-123	1160	10	7-14	75	31	14-36	27	30	14-48	29	21	5-34	37	32	12-40	31	45	24-58	23	30	13-51	59	19	11-33
INDIAN RIVER MEMORIAL HOSP VERO BEACH FL 32960	FL-124*	3150	10	8-15	367	21	16-30	114	25	19-37	77	12	8-28	117	26	15-31	84	48	28-50	49	10	8-33	195	17	14-28
JACKSON HOSP MARIANNA FL 32446	FL-125*	899	9	7-15	32	25	12-44	29	28	15-48	18	22	4-40	52	27	13-36	25	48	21-58	23	22	4-37	102	11	11-28
JACKSON MEMORIAL HOSP- MIAMI FL 33136	FL-126	2397	11	7-13	294	18	17-32	61	31	16-39	35	29	9-37	61	25	13-35	64	42	28-53	43	19	6-32	93	20	8-25
JACKSONVILLE MEDICAL CENTE JACKSONVILLE FL 32207	FL-127	649	12	7-15	25	8	8-41	36	25	16-46	11	0	3-49	34	29	10-38	16	44	16-61	10	10	3-52	62	24	10-31
JAMES ARCHER SMITH HOSP HOMESTEAD FL 33030	FL-128	541	14	8-16	34	35	11-41	18	33	13-53	6	0	1-63	37	27	14-42	19	32	17-59	15	33	3-44	53	21	9-31
JAY HOSP JAY FL 32565	FL-129*	176	11	7-19	5	80	5-74	2	50	2-90	5	20	1-68	6	17	6-69	8	0	15-74	8	13	2-56	29	14	9-39
JESS PARRISH MEM HOSP TITUSVILLE FL 32780	FL-130*	1748	13	9-16	117	29	19-38	77	23	19-41	42	10	6-31	75	32	14-33	49	65	29-57	70	10	10-33	134	21	14-29
JOHN F KENNEDY MEMORIAL HO LAKE WORTH FL 33460	FL-131	3401	13	10-17	341	23	18-32	144	19	21-37	84	23	10-29	179	26	17-31	147	39	31-48	96	39	16-37	191	20	15-29
JUPITER HOSP JUPITER FL 33458	FL-132	1594	10	8-15	141	18	16-34	58	31	16-40	24	8	6-38	41	22	13-39	47	36	24-52	24	4	7-41	111	20	11-28
KISSIMMEE MEMORIAL HOSP KISSIMMEE FL 32741	FL-133	912	11	8-16	72	22	15-38	26	31	14-49	15	20	3-42	58	29	12-34	39	31	24-55	13	8	3-46	89	25	12-31
L W BLAKE MEMORIAL HOSP BRADENTON FL 33529	FL-134*	4504	13	9-15	418	26	16-30	140	35	20-37	67	12	10-31	283	28	18-30	152	35	29-47	49	22	12-39	308	23	14-26
LAKE BUTLER HOSP & HAND SU LAKE BUTLER FL 32054	FL-135*	92	1	3-16	2	0	0-92	1	0	0-97	5	0	0-69	1	0	3-99	2	0	6-94	2	0	0-90	7	0	1-58
LAKE CITY MEDICAL CTR LAKE CITY FL 32055	FL-136*	576	8	7-14	19	42	14-55	13	15	10-57	18	11	4-39	24	8	8-41	12	67	17-68	16	13	4-43	63	14	9-30
LAKE MEDICAL CENTER LEESBURG FL 32749	FL-137*	1114	12	7-14	79	25	10-31	45	36	16-43	20	25	7-43	56	32	13-35	43	40	23-52	26	23	7-40	101	19	10-27
LAKE SEMINOLE HOSP SEMINOLE FL 33542	FL-138*	917	15	11-18	69	22	12-35	54	35	19-44	25	24	7-40	42	29	12-38	64	48	27-52	19	16	5-42	102	20	14-32
LAKE SHORE HOSP LAKE CITY FL 32055	FL-139	701	11	8-16	37	22	11-40	21	33	12-49	18	6	4-40	34	18	10-38	27	59	24-61	36	19	8-36	67	19	9-29
LAKE WALES HOSP ASSN INC LAKE WALES FL 33853	FL-140*	1002	14	9-17	55	24	12-37	51	29	16-41	25	16	4-35	79	25	12-31	73	48	26-49	40	5	4-30	89	15	10-28
LAKELAND REGIONAL MEDICAL LAKELAND FL 33802	FL-141	6710	10	8-14	551	19	17-30	245	25	21-34	89	17	10-29	327	21	17-28	221	38	31-46	120	13	11-30	386	20	14-26
LARGO MEDICAL CENTER HOSPI LARGO FL 33540	FL-142	3606	11	7-14	299	25	14-28	122	26	20-37	64	17	7-28	141	22	16-31	142	40	28-46	36	25	7-35	281	19	12-24
LARKIN GENERAL HOSP- MIAMI FL 33143	FL-143	389	6	6-15	30	17	10-42	11	18	10-60	8	0	4-59	13	31	8-53	7	14	11-73	5	0	2-69	29	10	9-39
LAS OLAS COMMUNITY HOSPITA FORT LAUDERDALE FL 33301	FL-144*	391	14	8-17	19	21	10-49	19	26	12-51	8	25	5-61	25	8	12-45	2	100	6-94	15	27	4-45	37	41	10-37
LAWNWOOD MEDICAL CTR INC FORT PIERCE FL 33450	FL-145*	2127	13	9-16	211	28	19-35	78	27	17-37	48	19	6-30	117	21	15-31	73	27	27-50	29	14	10-43	156	24	14-28
LEE MEMORIAL HOSP- FORT MYERS FL 33902	FL-146	3858	11	8-14	322	20	17-32	181	22	20-34	65	15	7-28	161	27	16-30	116	46	28-47	62	21	11-35	256	20	13-26
LEESBURG REGIONAL MEDICAL LEESBURG FL 32748	FL-147*	2090	12	9-16	188	25	17-33	107	21	19-37	41	15	8-34	117	21	14-30	102	38	27-47	34	18	6-35	174	16	12-26
LYKES MEMORIAL HOSP- BROOKSVILLE FL 33512	FL-148	1401	12	9-16	104	22	14-33	76	26	17-38	54	13	8-31	68	29	14-35	52	21	24-51	27	15	6-37	136	19	12-27

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
IMPERIAL POINT MEDICAL CEN FORT LAUDERDALE FL 33308	10	30	4-58	6	33	14-81	32	9	4-27	3	0	0-100	105	6	3-13	50	6	1-17	10	0	0-91	51	0	2-17	88	1	0-9
INDIAN RIVER MEMORIAL HOSP VERO BEACH FL 32960	22	23	9-50	19	42	18-61	93	11	5-18	8	0	0-98	295	3	4-10	274	4	1-9	29	0	0-81	207	4	3-9	303	1	1-4
JACKSON HOSP MARIANNA FL 32446	20	30	10-53	7	43	8-70	26	0	2-26	.	.		102	1	1-11	71	3	1-14	9	0	0-98	60	3	1-14	53	0	0-15
JACKSON MEMORIAL HOSP- MIAMI FL 33136	56	14	3-34	14	71	17-66	33	12	2-23	3	0	0-100	105	15	3-14	99	7	2-13	35	0	0-52	152	9	2-9	118	3	0-7
JACKSONVILLE MEDICAL CENTE JACKSONVILLE FL 32207	5	80	4-73	12	33	14-65	17	6	1-34	2	0	0-100	85	6	1-11	38	16	2-23	1	0	0-100	44	5	1-16	51	2	0-18
JAMES ARCHER SMITH HOSP HOMESTEAD FL 33030	4	50	3-78	5	80	6-75	17	12	1-33	2	0	0-100	59	2	1-15	14	7	1-38	5	0	0-94	36	6	1-20	21	0	0-38
JAY HOSP JAY FL 32565	5	0	1-71	2	0	3-91	2	0	0-92	.	.		28	7	0-22	1	0	0-99	1	0	0-100	27	#	0-22	5	0	0-74
JESS PARRISH MEM HOSP TITUSVILLE FL 32780	24	33	10-50	16	44	21-68	31	10	2-25	6	0	0-100	176	4	2-9	111	4	2-14	24	0	0-62	126	5	2-10	112	1	0-7
JOHN F KENNEDY MEMORIAL HO LAKE WORTH FL 33460	23	22	19-62	28	29	23-60	124	10	5-17	11	0	0-94	343	8	3-9	195	6	2-11	22	0	0-84	309	4	3-8	227	1	1-5
JUPITER HOSP JUPITER FL 33458	10	30	9-65	17	35	21-67	48	6	3-21	4	0	0-100	204	6	3-10	101	3	1-12	25	0	0-74	110	4	2-11	157	1	0-6
KISSIMMEE MEMORIAL HOSP KISSIMMEE FL 32741	7	29	7-70	6	0	5-68	14	14	1-39	2	0	0-100	95	5	2-12	46	7	1-18	12	0	0-99	113	3	2-10	61	0	0-13
L W BLAKE MEMORIAL HOSP BRADENTON FL 33529	36	14	13-48	49	41	23-52	128	7	5-17	33	0	0-71	590	6	3-7	168	5	2-12	47	0	0-15	426	6	3-8	362	2	1-4
LAKE BUTLER HOSP & HAND SU LAKE BUTLER FL 32054	.	.		2	0	1-89	.	.		.	.		4	25	0-79	.	.		.	.		7	0	0-67	22	0	0-50
LAKE CITY MEDICAL CTR LAKE CITY FL 32055	10	30	5-59	7	29	9-72	2	0	0-98	.	.		71	1	1-13	27	0	1-25	5	0	0-100	49	2	1-15	18	0	0-34
LAKE MEDICAL CENTER LEESBURG FL 32749	5	20	3-72	9	44	11-68	28	7	3-28	5	0	0-100	142	5	2-10	54	0	1-16	35	0	0-60	108	2	1-10	64	2	0-12
LAKE SEMINOLE HOSP SEMINOLE FL 33542	9	56	11-70	7	43	12-75	38	5	3-24	1	0	0-100	90	2	2-12	51	4	1-17	11	0	0-100	102	5	2-11	43	0	0-16
LAKE SHORE HOSP LAKE CITY FL 32055	4	25	2-77	7	29	9-72	29	3	2-26	1	0	0-100	64	0	1-14	46	2	2-20	6	0	0-99	75	4	1-12	29	0	0-30
LAKE WALES HOSP ASSN INC LAKE WALES FL 33853	12	50	13-66	11	27	12-65	28	4	2-25	4	0	0-100	125	1	1-9	38	3	1-20	12	0	0-100	95	6	2-12	25	4	0-34
LAKELAND REGIONAL MEDICAL LAKELAND FL 33802	53	19	8-39	46	50	26-57	135	10	4-15	48	0	0-30	636	5	3-7	340	4	1-9	66	2	0-38	700	5	3-6	529	2	0-3
LARGO MEDICAL CENTER HOSPI LARGO FL 33540	23	9	9-49	33	24	19-53	72	10	3-18	7	0	0-99	402	2	2-7	151	5	1-11	32	0	0-88	516	5	3-7	256	2	0-4
LARKIN GENERAL HOSP- MIAMI FL 33143	1	0	0-97	4	25	8-83	4	25	0-79	24	0	0-77	31	3	1-22	8	13	1-54	1	0	0-100	31	0	1-21	15	0	0-65
LAS OLAS COMMUNITY HOSPITA FORT LAUDERDALE FL 33301	6	50	7-74	9	11	9-65	6	0	1-63	13	0	0-97	34	6	1-21	35	11	2-24	1	0	0-100	26	0	1-24	26	4	0-26
LAWNWOOD MEDICAL CTR INC FORT PIERCE FL 33450	24	25	10-49	21	48	20-62	71	10	4-19	16	0	0-96	195	7	3-10	117	5	1-12	14	0	0-99	253	2	3-8	90	4	1-9
LEE MEMORIAL HOSP- FORT MYERS FL 33902	18	22	11-55	30	40	20-56	127	5	4-16	18	0	0-97	381	5	3-8	171	4	1-11	39	0	0-40	306	4	3-9	504	1	0-4
LEESBURG REGIONAL MEDICAL LEESBURG FL 32748	28	32	9-47	25	32	19-57	61	8	3-19	1	0	0-100	248	5	2-8	134	2	1-11	11	0	0-100	174	6	2-9	69	3	0-10
LYKES MEMORIAL HOSP- BROOKSVILLE FL 33512	7	29	3-64	14	29	15-64	36	3	3-24	.	.		189	4	2-9	96	5	1-13	29	0	0-76	135	4	2-10	59	2	0-12

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MADISON CO MEMORIAL HOSP MADISON FL 32340	FL-149*	254	15	11-22	6	17	6-70	12	17	12-62	5	20	1-68	21	33	9-45	13	23	18-68	21	10	7-44	45	27	13-39
MANATEE MEMORIAL HOSP- BRADENTON FL 33505	FL-150*	3961	13	9-15	327	25	16-30	163	27	20-36	89	11	8-27	255	26	17-29	168	40	30-46	75	20	8-30	296	24	14-26
MARINERS HOSP TAVERNIER FL 33070	FL-151*	358	7	7-16	11	45	8-59	6	17	6-69	3	0	1-81	28	25	10-41	14	7	16-64	5	20	3-70	36	11	8-35
MARION COMMUNITY HOSPITAL OCALA FL 32670	FL-152*	2961	10	8-15	300	24	17-31	67	19	18-41	63	14	10-33	136	20	15-30	87	28	26-47	55	18	9-34	168	16	12-27
MARTIN MEMORIAL HOSP STUART FL 33495	FL-153*	3562	12	8-14	378	25	16-31	131	27	19-36	81	16	8-27	126	17	15-31	134	34	29-48	38	13	7-35	216	22	11-24
MEASE HOSP- CLINIC DUNEDIN FL 33528	FL-154*	2990	11	9-15	334	15	15-30	138	22	19-35	49	18	10-34	116	24	16-33	109	43	30-50	40	30	11-40	157	18	13-27
MEASE HOSPITAL COUNTRYSIDE SAFETY HARBOR FL 33572	FL-155*	1122	12	9-16	112	22	15-35	62	27	15-37	23	13	4-36	72	24	15-35	38	39	25-56	29	28	8-40	63	19	11-32
MEDICAL CENTER PUNTA GORDA FL 33950	FL-156	1657	9	8-15	126	21	17-36	67	25	17-40	37	8	6-32	83	25	14-33	54	41	24-51	17	12	6-46	155	11	11-26
MEMORIAL HOSP HOLLYWOOD FL 33021	FL-157	4356	12	9-16	350	19	16-30	127	36	22-39	54	13	8-31	211	24	17-30	239	37	32-47	88	23	16-38	258	23	16-29
MEMORIAL HOSP SARASOTA FL 33579	FL-158	7065	10	8-14	684	19	15-28	261	27	23-36	115	18	10-28	286	20	18-29	303	35	32-46	72	19	11-33	422	18	14-25
MEMORIAL HOSP OF TAMPA LTD TAMPA FL 33609	FL-159*	1461	13	9-16	142	20	15-33	49	22	17-43	42	12	6-31	71	31	14-34	44	34	27-56	37	16	6-34	122	25	11-27
MEMORIAL MEDICAL CTR OF JA JACKSONVILLE FL 32216	FL-160*	2799	11	9-15	171	20	16-33	105	32	20-38	73	16	10-31	120	19	16-32	102	31	28-49	57	11	9-33	232	19	13-25
MERCY HOSP MIAMI FL 33133	FL-161*	2681	10	9-15	203	33	19-35	65	23	20-44	36	17	12-41	100	23	16-34	81	28	29-51	39	13	10-38	184	23	17-31
METHODIST HOSP JACKSONVILLE FL 32209	FL-162	2203	13	9-15	132	21	14-32	99	22	18-37	34	12	7-34	135	18	15-30	54	33	24-51	116	23	10-29	178	27	12-26
METROPOLITAN GENERAL HOSP- PINELLAS PARK FL 33565	FL-163	1140	12	9-16	77	23	17-40	36	28	17-46	23	9	5-38	72	42	14-35	45	44	23-51	33	15	7-37	68	15	12-33
MIAMI GENERAL HOSP MIAMI FL 33169	FL-164*	443	15	9-18	33	21	12-43	10	30	8-60	6	50	4-67	25	48	12-46	16	38	20-65	12	25	6-53	37	22	12-41
MIAMI HEART INSTITUTE MIAMI BEACH FL 33140	FL-165*	2864	8	9-16	201	22	16-32	62	18	19-43	58	10	11-34	187	19	18-32	167	19	31-48	18	22	6-45	171	8	15-30
MORROW MEM HOSP AUBURNDALE FL 33823	FL-166*	217	8	8-19	8	38	6-62	12	17	9-56	2	0	0-94	18	17	7-44	4	50	15-90	10	20	4-54	29	3	9-39
MORTON F PLANT HOSP- CLEARWATER FL 33517	FL-167	7341	11	8-14	683	20	17-30	271	30	23-36	120	13	10-27	300	26	18-30	226	34	31-46	110	22	9-29	408	17	15-26
MOUNT SINAI MEDICAL CENTER MIAMI BEACH FL 33140	FL-168	5193	12	11-17	426	23	17-31	166	28	24-39	122	16	13-30	247	18	19-31	296	36	37-51	60	12	13-38	378	20	18-30
MUNROE REGIONAL MEDICAL CE OCALA FL 32670	FL-169	2558	13	9-15	124	27	16-35	123	28	19-36	80	19	10-30	166	16	16-29	145	43	28-45	53	23	7-31	167	19	12-27
NAPLES COMMUNITY HOSP INC NAPLES FL 33940	FL-170	4314	11	8-14	440	23	15-29	194	25	21-35	100	14	10-28	224	20	16-28	123	42	28-47	56	16	10-34	279	22	12-24
NASSAU GENERAL HOSP FERNANDINA BEACH FL 32034	FL-171*	302	13	8-17	7	29	5-64	11	27	9-59	7	0	0-60	18	17	8-45	4	50	7-82	21	5	5-41	35	34	11-39
NORTH BEACH COMMUNITY HOSP FORT LAUDERDALE FL 33308	FL-172*	571	12	8-16	35	26	10-39	17	35	15-58	10	30	3-52	31	32	12-42	21	38	23-64	14	7	6-49	49	16	11-34
NORTH BROWARD HOSP POMPANO BEACH FL 33064	FL-173	3150	12	10-17	255	26	18-33	158	24	22-38	84	14	11-31	188	25	18-32	156	38	31-48	44	9	8-34	223	13	15-28
NORTH GABLES HOSP CORAL GABLES FL 33134	FL-174	492	5	7-15	66	12	13-36	2	0	2-90	6	0	1-63	17	12	9-49	5	20	8-78	10	30	4-54	35	3	12-40

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MADISON CO MEMORIAL HOSP MADISON FL 32340	2	50	2-90	2	0	2-90	.	.		.	.		17	6	0-33	4	0	0-74	.	.		28	0	1-22	7	0	0-79
MANATEE MEMORIAL HOSP- BRADENTON FL 33505	24	25	10-51	41	49	24-56	134	13	4-15	16	0	0-95	463	6	3-8	143	8	2-12	35	0	0-43	354	3	2-7	199	1	0-5
MARINERS HOSP TAVERNIER FL 33070	1	0	0-98	5	0	6-76	6	0	0-63	.	.		37	3	1-19	24	0	0-27	.	.		56	2	1-14	20	0	0-41
MARION COMMUNITY HOSPITAL OCALA FL 32670	18	17	11-56	28	11	20-57	38	11	6-29	6	0	0-100	354	5	2-8	201	1	1-10	44	0	0-50	325	4	3-8	161	1	1-6
MARTIN MEMORIAL HOSP STUART FL 33495	20	20	8-49	17	47	17-62	74	9	3-18	18	6	0-91	464	5	3-8	275	4	1-9	45	2	0-51	298	6	2-8	269	1	1-5
MEASE HOSP- CLINIC DUNEDIN FL 33528	15	53	14-63	37	41	24-57	98	16	5-18	6	0	0-97	320	5	3-9	147	3	1-11	32	3	0-78	253	4	3-9	207	1	0-5
MEASE HOSPITAL COUNTRYSIDE SAFETY HARBOR FL 33572	5	40	4-73	11	45	12-65	24	0	1-28	1	0	0-100	117	3	2-11	56	4	0-16	23	0	0-85	117	2	1-10	33	6	0-22
MEDICAL CENTER PUNTA GORDA FL 33950	4	0	6-81	18	11	17-60	33	6	3-26	13	0	0-83	144	4	2-11	84	2	1-13	15	0	0-88	188	4	2-9	105	1	0-8
MEMORIAL HOSP HOLLYWOOD FL 33021	16	25	13-61	20	30	20-63	102	9	4-17	10	0	0-98	362	4	4-9	205	10	2-11	26	0	0-95	538	7	3-8	187	2	0-5
MEMORIAL HOSP SARASOTA FL 33579	37	16	11-46	55	40	25-54	250	8	5-14	59	0	0-29	578	7	3-8	448	2	1-9	61	2	0-23	983	5	3-7	526	1	0-4
MEMORIAL HOSP OF TAMPA LTD TAMPA FL 33609	19	21	8-51	24	25	16-55	38	24	4-27	48	0	0-38	137	5	2-11	80	5	1-13	6	0	0-100	78	1	2-13	56	4	0-12
MEMORIAL MEDICAL CTR OF JA JACKSONVILLE FL 32216	39	10	9-43	34	29	22-56	91	12	4-18	8	0	0-100	273	4	2-8	142	4	2-12	33	0	0-70	395	4	3-7	96	1	0-8
MERCY HOSP MIAMI FL 33133	30	27	14-53	20	40	19-61	54	7	5-24	12	0	0-92	289	3	4-11	121	5	2-13	27	0	0-52	298	4	2-8	136	1	0-6
METHODIST HOSP JACKSONVILLE FL 32209	27	30	7-45	26	38	18-55	46	7	3-22	6	0	0-100	263	5	3-9	101	6	2-14	14	0	0-96	127	7	2-11	71	3	0-10
METROPOLITAN GENERAL HOSP- PINELLAS PARK FL 33565	8	13	3-61	13	15	12-62	29	10	4-29	3	0	0-100	120	5	2-11	68	1	2-16	9	0	0-100	137	7	2-10	72	0	0-10
MIAMI GENERAL HOSP MIAMI FL 33169	2	50	0-93	2	50	4-92	4	0	2-74	1	0	0-100	33	0	2-23	42	7	2-20	6	0	0-100	42	2	1-17	14	7	0-60
MIAMI HEART INSTITUTE MIAMI BEACH FL 33140	18	22	11-56	8	13	15-76	28	14	5-32	1	0	0-100	255	3	3-10	112	0	1-12	16	0	0-91	701	3	3-7	109	0	0-8
MORROW MEM HOSP AUBURNDALE FL 33823	7	0	5-66	1	0	0-97	.	.		.	.		38	3	1-20	8	0	0-67	3	0	0-100	19	0	1-29	4	0	0-100
MORTON F PLANT HOSP- CLEARWATER FL 33517	69	25	12-41	38	32	25-58	179	9	4-14	19	0	0-80	801	5	3-8	341	6	2-10	85	0	0-25	807	5	3-7	623	2	1-3
MOUNT SINAI MEDICAL CENTER MIAMI BEACH FL 33140	17	12	7-52	26	38	22-60	139	2	4-16	9	0	0-96	410	6	4-10	210	3	2-12	40	3	0-23	717	7	4-8	259	1	1-5
MUNROE REGIONAL MEDICAL CE OCALA FL 32670	31	32	11-48	29	45	22-59	98	5	3-16	3	0	0-100	249	6	2-9	99	4	1-13	17	0	0-76	278	3	2-8	141	2	0-6
NAPLES COMMUNITY HOSP INC NAPLES FL 33940	24	25	7-46	30	33	21-58	133	7	3-14	7	0	0-100	476	6	3-8	245	2	1-10	55	0	0-31	254	4	2-8	346	1	0-4
NASSAU GENERAL HOSP FERNANDINA BEACH FL 32034	11	36	8-61	5	80	5-74	5	0	0-69	.	.		40	5	2-19	14	21	1-38	1	0	0-100	34	0	1-19	14	0	0-52
NORTH BEACH COMMUNITY HOSP FORT LAUDERDALE FL 33308	3	0	1-82	6	50	12-78	28	4	2-26	7	0	0-99	40	3	1-18	40	8	1-20	2	0	0-100	39	0	1-18	48	4	0-15
NORTH BROWARD HOSP POMPANO BEACH FL 33064	9	56	7-63	27	22	21-58	121	7	5-18	9	0	0-86	314	7	3-9	138	5	1-12	21	0	0-65	356	4	3-8	203	2	1-6
NORTH GABLES HOSP CORAL GABLES FL 33134	1	0	0-99	2	50	5-94	1	0	0-98	2	0	0-100	88	2	2-13	57	4	1-16	16	0	0-100	36	0	1-19	18	0	0-46

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTH MIAMI MEDICAL CENTER MIAMI FL 33181	FL-175	1532	14	10-17	91	23	15-36	63	32	20-43	30	20	7-36	97	22	16-34	72	47	31-55	17	35	8-48	101	33	15-33
NORTH SHORE HOSP MIAMI FL 33150	FL-176	1744	13	9-16	160	26	16-33	62	27	17-40	69	12	9-30	63	19	12-33	71	45	32-56	33	42	9-39	136	16	14-30
NORTHWEST REGIONAL HOSP MARGATE FL 33063	FL-177*	1304	12	9-16	71	15	11-33	46	39	17-43	30	20	6-35	96	26	15-33	71	30	28-52	24	25	8-43	115	18	14-31
ORLANDO GENERAL HOSP- ORLANDO FL 32807	FL-178*	767	12	6-14	36	33	13-43	29	38	14-46	9	0	3-54	26	27	8-40	33	48	23-56	23	22	8-43	43	7	7-31
ORLANDO REGIONAL MEDICAL C ORLANDO FL 32806	FL-179	4345	12	9-15	404	19	17-31	173	30	20-35	90	21	11-31	204	21	16-29	142	33	27-45	103	26	11-31	247	24	15-27
ORMOND BEACH MEMORIAL HOSP ORMOND BEACH FL 32074	FL-180*	2518	10	8-14	188	19	17-34	75	25	19-41	54	19	8-31	93	27	16-34	90	38	26-47	38	21	8-37	160	16	13-28
PALM BEACH GARDENS COMMUNI PALM BEACH FL 33410	FL-181	1597	9	8-15	104	14	14-34	61	15	16-39	33	15	8-37	76	21	15-35	73	34	26-50	13	15	5-49	89	17	10-28
PALM SPRINGS GENERAL HOSP- HIALEAH FL 33012	FL-182*	1104	10	8-15	48	17	10-36	34	15	16-46	22	32	6-41	55	20	13-35	40	40	24-55	26	23	7-40	103	20	12-30
PALMETTO GENERAL HOSP- HIALEAH FL 33010	FL-183	1489	11	9-16	106	24	17-37	50	36	17-43	34	21	10-39	77	34	16-36	49	37	24-52	15	27	5-47	120	22	14-30
PALMS OF PASADENA HOSPITAL SAINT PETERSBURG FL 33707	FL-184	3039	12	10-17	247	23	15-31	109	25	20-38	89	12	12-32	196	20	17-31	129	46	31-50	65	31	9-31	318	21	16-28
PALMS WEST HOSP LOXAHATCHEE FL 33470	FL-185	232	17	9-20	13	31	11-59	11	45	11-62	2	0	0-89	15	27	8-49	17	47	19-63	5	0	1-69	16	38	8-49
PAN AMERICAN HOSP- CORP MIAMI FL 33126	FL-186	1184	11	8-15	80	16	12-33	27	37	15-50	15	13	7-50	36	36	13-41	29	34	25-61	29	31	9-42	89	21	14-32
PARKWAY REGIONAL MEDICAL C MIAMI FL 33169	FL-187	3658	11	9-15	245	18	16-32	119	28	22-40	83	16	9-28	177	32	18-31	161	38	35-52	42	19	10-38	249	14	16-29
PEMBROKE PINES GENERAL HOS PEMBROKE PINES FL 33024	FL-188*	1310	11	9-16	87	24	16-37	24	33	12-47	27	11	6-37	81	23	15-34	59	39	26-51	34	24	10-40	119	19	13-29
PENINSULA MEDICAL CENTER ORMOND BEACH FL 32074	FL-189	751	13	8-16	31	29	10-42	27	15	14-47	31	6	5-32	30	20	11-42	24	38	21-58	19	32	5-42	82	28	12-31
PLANTATION GENERAL HOSP- PLANTATION FL 33317	FL-190	1336	11	9-15	78	17	14-36	44	20	17-44	24	21	9-44	109	31	16-33	65	34	27-52	34	24	8-38	70	20	11-32
POLK GENERAL HOSP BARTOW FL 33830	FL-191*	306	19	6-15	9	44	4-57	8	75	6-63	11	45	3-50	12	33	7-54	19	84	20-62	12	17	3-47	34	21	8-35
PUTNAM COMMUNITY HOSP- PALATKA FL 32077	FL-192*	1531	10	8-15	80	31	19-41	51	27	16-41	35	20	6-32	86	21	13-31	72	33	27-50	35	9	5-33	175	13	10-24
RIVERSIDE HOSP JACKSONVILLE FL 32204	FL-193*	1336	11	8-15	82	26	15-37	53	21	16-41	26	8	6-36	75	23	15-35	31	45	22-56	47	17	8-33	125	10	10-25
RIVERSIDE HOSP NEW PORT RICHEY FL 33552	FL-194	890	12	9-16	79	27	14-35	27	30	12-45	17	6	4-41	42	21	14-40	36	47	23-55	10	10	4-53	71	20	13-34
SACRED HEART HOSP PENSACOLA FL 32504	FL-195	2295	12	8-15	146	21	16-33	90	24	18-38	46	22	9-34	103	28	14-30	98	24	25-45	56	25	13-38	165	23	13-28
SANTA ROSA HOSP MILTON FL 32570	FL-196	426	14	8-16	11	27	6-54	10	50	9-62	12	25	6-52	28	36	12-44	24	50	19-57	11	9	2-49	42	26	10-36
SEVEN RIVERS COMMUNITY HOS CRYSTAL RIVER FL 32629	FL-197	1446	14	9-16	98	26	17-37	55	24	18-43	43	26	9-35	85	16	14-33	59	46	25-50	49	35	13-40	144	19	10-25
SHANDS TEACHING HOSP CLI GAINESVILLE FL 32610	FL-198	1989	7	6-13	339	14	16-31	32	9	11-41	29	10	8-39	30	27	11-41	25	20	19-55	13	8	5-50	68	16	9-29
SOUTH FLORIDA BAPTIST HOSP PLANT CITY FL 33566	FL-199*	1147	14	9-16	58	12	12-36	57	33	17-42	19	16	6-42	58	24	12-34	46	48	25-54	26	15	6-38	133	25	11-26
SOUTH LAKE MEMORIAL HOSP- CLERMONT FL 32711	FL-200*	543	11	8-16	32	28	14-46	25	36	14-49	8	0	1-55	21	19	7-41	26	35	22-59	11	36	4-52	58	7	8-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTH MIAMI MEDICAL CENTER MIAMI FL 33181	13	46	15-67	22	23	20-61	56	14	4-21	13	0	0-91	90	8	2-13	76	4	1-14	22	5	0-88	147	5	3-10	60	2	0-12
NORTH SHORE HOSP MIAMI FL 33150	19	32	10-54	13	46	16-67	60	7	4-20	8	0	0-100	147	5	2-9	93	9	2-14	10	0	0-99	131	2	2-10	95	0	0-8
NORTHWEST REGIONAL HOSP MARGATE FL 33063	5	20	3-73	13	38	21-72	49	12	4-23	2	0	0-100	130	5	2-12	76	7	2-15	8	0	0-100	128	4	2-10	56	2	0-12
ORLANDO GENERAL HOSP- ORLANDO FL 32807	9	11	5-62	4	25	4-78	14	14	1-38	2	0	0-100	90	6	1-12	27	7	1-25	6	17	0-100	49	8	1-15	59	0	0-13
ORLANDO REGIONAL MEDICAL C ORLANDO FL 32806	51	27	11-43	42	19	20-51	153	12	4-15	35	0	0-58	386	8	3-8	185	4	2-11	41	5	0-46	468	4	3-7	307	1	0-4
ORMOND BEACH MEMORIAL HOSP ORMOND BEACH FL 32074	27	37	12-51	28	32	19-55	59	12	4-21	8	0	0-100	271	4	3-9	166	2	1-10	20	0	0-46	411	5	3-7	123	5	0-7
PALM BEACH GARDENS COMMUNI PALM BEACH FL 33410	11	18	8-61	11	27	14-68	34	15	3-24	8	0	0-100	153	5	2-11	66	2	1-15	17	0	0-96	352	4	3-9	79	1	0-9
PALM SPRINGS GENERAL HOSP- HIALEAH FL 33012	1	0	0-97	15	53	19-67	7	0	1-57	5	0	0-100	149	3	1-9	84	7	3-16	25	0	0-80	87	3	1-11	47	2	0-15
PALMETTO GENERAL HOSP- HIALEAH FL 33010	20	10	7-48	20	15	19-61	37	8	5-28	3	0	0-100	134	4	3-12	100	1	1-12	13	0	0-84	147	1	2-10	104	1	0-8
PALMS OF PASADENA HOSPITAL SAINT PETERSBURG FL 33707	14	21	9-57	35	31	21-55	119	8	5-18	4	0	0-100	282	4	3-10	120	2	2-13	31	0	0-49	280	4	3-9	128	2	1-7
PALMS WEST HOSP LOXAHATCHEE FL 33470	2	0	0-93	5	40	7-76	7	0	1-57	4	0	0-100	19	11	1-30	10	10	1-47	.	.		25	12	1-24	17	0	0-55
PAN AMERICAN HOSP- CORP MIAMI FL 33126	12	50	11-64	8	13	7-66	15	20	3-40	1	0	0-100	180	4	3-11	73	5	1-15	21	0	0-66	105	5	2-11	49	2	0-14
PARKWAY REGIONAL MEDICAL C MIAMI FL 33169	24	25	10-50	30	33	18-53	81	15	4-18	47	0	0-28	296	4	3-9	160	6	2-11	13	0	0-98	481	3	3-7	225	2	1-5
PEMBROKE PINES GENERAL HOS PEMBROKE PINES FL 33024	9	22	4-60	7	14	14-78	34	12	4-28	1	0	0-100	115	3	2-11	54	6	2-18	5	0	0-100	175	5	2-9	66	0	0-11
PENINSULA MEDICAL CENTER ORMOND BEACH FL 32074	11	27	8-61	8	50	13-74	19	0	2-32	4	0	0-100	87	1	2-13	41	12	2-21	12	0	0-99	60	13	2-15	46	2	0-15
PLANTATION GENERAL HOSP- PLANTATION FL 33317	11	9	5-57	7	29	10-73	30	13	3-27	14	0	0-98	128	5	2-10	74	5	2-15	12	0	0-99	183	2	2-9	90	0	0-8
POLK GENERAL HOSP BARTOW FL 33830	1	0	0-97	2	0	1-89	5	0	0-72	.	.		23	4	0-26	7	0	0-61	.	.		15	7	0-36	13	0	0-92
PUTNAM COMMUNITY HOSP- PALATKA FL 32077	19	37	8-51	6	33	10-76	33	6	2-25	6	0	0-100	167	3	2-9	80	4	1-14	5	0	0-100	198	2	2-9	91	0	0-8
RIVERSIDE HOSP JACKSONVILLE FL 32204	14	14	6-53	23	26	17-56	40	13	2-21	9	0	0-79	132	7	2-11	60	2	1-15	18	0	0-91	124	4	2-10	54	0	0-13
RIVERSIDE HOSP NEW PORT RICHEY FL 33552	6	33	5-70	7	57	13-76	15	7	2-39		.		95	6	3-14	49	2	1-18	14	0	0-99	105	5	2-11	59	2	0-12
SACRED HEART HOSP PENSACOLA FL 32504	19	42	5-47	26	31	17-54	60	3	3-18	5	0	0-100	248	7	3-10	109	7	2-13	12	0	0-100	296	6	3-8	147	2	0-6
SANTA ROSA HOSP MILTON FL 32570	10	20	5-59	.	.		17	12	1-34	3	0	0-100	43	5	1-17	28	0	0-27	3	0	0-100	48	2	1-15	21	0	0-55
SEVEN RIVERS COMMUNITY HOS CRYSTAL RIVER FL 32629	9	22	6-63	6	33	12-78	38	13	3-24	1	0	0-100	179	4	2-10	101	4	1-12	20	0	0-93	148	5	2-9	36	3	0-19
SHANDS TEACHING HOSP CLI GAINESVILLE FL 32610	76	7	2-32	6	50	14-81	23	13	2-29	123	0	0-8	117	6	2-12	46	4	1-18	16	0	0-88	150	3	2-10	161	0	0-6
SOUTH FLORIDA BAPTIST HOSP PLANT CITY FL 33566	9	22	8-65	33	24	20-54	44	9	3-21	3	0	0-100	102	9	3-14	48	6	2-19	10	0	0-52	105	10	2-11	63	0	0-11
SOUTH LAKE MEMORIAL HOSP- CLERMONT FL 32711	1	0	2-98	5	40	8-77	14	0	1-38	1	0	0-100	62	11	2-16	24	0	1-27	3	0	0-100	79	3	1-11	14	0	0-64

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SOUTH MIAMI HOSP MIAMI FL 33143	FL-201	2468	9	8-15	238	25	16-32	73	21	20-42	68	15	7-28	107	14	15-32	66	36	27-51	20	10	6-42	205	12	12-26
SOUTH SEMINOLE COMMUNITY H LONGWOOD FL 32750	FL-202	748	13	9-16	47	40	17-45	34	15	15-45	22	18	6-39	52	19	12-35	23	65	22-60	25	28	6-38	72	15	10-29
SOUTH SHORE HOSP MEDICAL MIAMI BEACH FL 33139	FL-203	1046	14	12-19	32	31	14-47	40	28	21-50	22	9	8-43	56	23	16-39	25	52	26-63	31	32	13-46	119	30	20-38
SOUTHEASTERN MEDICAL CENTE MIAMI FL 33162	FL-204	1168	20	12-20	54	24	15-40	48	31	18-44	24	29	8-42	93	27	16-34	52	62	30-57	36	42	11-40	123	43	20-38
SOUTHWEST FLORIDA REGIONAL FORT MYERS FL 33901	FL-205	5276	8	8-14	400	18	17-31	168	18	19-34	66	20	11-33	278	22	17-28	210	24	29-44	66	33	13-37	213	18	13-27
ST ANTHONY'S HOSP INC SAINT PETERSBURG FL 33705	FL-206	4351	11	9-15	349	17	14-29	196	23	23-37	106	18	12-31	222	25	20-32	156	44	32-50	90	14	11-32	248	20	17-30
ST AUGUSTINE GENERAL HOSP- SAINT AUGUSTINE FL 32084	FL-207*	842	14	9-16	61	20	15-39	15	27	10-53	15	20	5-45	39	33	14-41	49	49	27-55	25	24	6-39	71	15	10-30
ST CLOUD HOSP SAINT CLOUD FL 32769	FL-208*	806	10	8-15	40	30	13-41	34	29	18-49	18	22	6-43	34	26	11-39	28	43	25-61	23	4	7-41	60	20	11-32
ST FRANCIS HOSP INC MIAMI BEACH FL 33141	FL-209	2527	12	11-17	154	21	17-35	88	27	22-43	43	16	10-37	147	24	19-34	130	48	34-53	14	43	7-52	254	12	16-29
ST JOSEPH HOSP OF PORT CHA PUNTA GORDA FL 33952	FL-210	1619	11	9-15	114	26	16-36	67	34	18-40	42	17	8-34	96	19	16-34	63	49	27-52	19	26	8-47	155	15	12-26
ST JOSEPHS HOSP TAMPA FL 33677	FL-211*	5613	11	8-14	505	23	18-32	151	28	20-36	105	18	9-27	256	25	17-28	118	34	27-46	131	20	10-28	360	24	16-27
ST LUKES HOSP JACKSONVILLE FL 32216	FL-212	1609	10	7-14	111	22	15-35	44	36	15-42	26	8	6-38	68	32	13-33	46	33	25-53	22	9	5-40	115	21	12-28
ST MARYS HOSP WEST PALM BEACH FL 33407	FL-213	2839	12	9-16	270	20	14-29	125	25	21-39	82	17	10-30	142	24	16-31	123	43	30-49	47	26	8-33	190	22	14-27
ST VINCENTS MEDICAL CENTER JACKSONVILLE FL 32204	FL-214	4396	10	8-15	258	20	18-33	166	25	19-34	97	19	12-31	254	22	17-29	107	24	27-47	150	15	11-29	325	22	15-27
SUN COAST HOSP INC LARGO FL 33540	FL-215*	1889	14	9-16	141	22	13-31	58	36	19-43	61	16	12-36	98	30	16-33	56	46	27-53	33	18	6-35	156	17	14-28
SUWANNEE CO HOSP INC LIVE OAK FL 32060	FL-216	358	23	11-21	14	86	18-67	18	33	15-56	9	33	3-54	23	13	9-43	22	64	21-60	31	23	9-40	47	26	9-33
TALLAHASSEE COMMUNITY HOSP TALLAHASSEE FL 32308	FL-217	1053	12	7-14	72	35	15-38	35	34	15-45	18	22	5-42	42	14	12-37	20	30	17-57	39	31	8-35	86	23	11-29
TALLAHASSEE MEMORIAL REG M TALLAHASSEE FL 32304	FL-218	4250	12	9-15	314	25	17-32	173	19	20-35	77	22	9-29	221	21	16-29	167	32	28-45	131	19	13-33	250	22	13-25
TAMPA BAY COMMUNITY HOSP TAMPA FL 33611	FL-219*	310	14	8-17	13	23	8-53	12	33	11-59	8	25	1-55	21	19	9-45	9	44	16-73	14	14	4-46	34	12	7-34
TAMPA GENERAL HOSP TAMPA FL 33606	FL-220*	2639	9	6-13	234	18	18-34	34	41	15-45	26	27	9-42	45	13	12-37	64	41	24-48	28	7	6-37	91	18	10-27
TARPON SPRINGS GENERAL HOS TARPON SPRINGS FL 33589	FL-221*	2186	12	9-15	160	21	14-31	93	25	19-38	52	21	8-32	122	25	16-32	85	34	27-49	67	25	9-32	146	27	15-30
THE BEACHES HOSP JACKSONVILLE FL 32250	FL-222	556	11	7-15	27	19	11-44	21	19	12-50	14	36	4-46	42	26	11-36	17	47	17-60	12	0	3-48	49	14	8-31
TOWN COUNTRY HOSP TAMPA FL 33615	FL-223	856	9	7-14	51	25	16-43	19	11	11-50	24	25	5-37	38	32	12-39	18	56	21-64	43	12	7-33	65	18	10-30
UNIVERSITY COMMUNITY HOSP- TAMPA FL 33612	FL-224*	2983	11	8-14	204	27	18-34	84	23	18-38	52	27	8-32	112	23	14-31	108	42	29-49	50	16	8-33	220	21	14-27
UNIVERSITY GEN HOSP OF SEM SEMINOLE FL 33542	FL-225	1069	12	9-16	79	27	18-40	36	44	17-47	25	12	6-37	60	32	14-37	37	35	24-55	21	14	5-40	60	17	11-33
UNIVERSITY HOSP HOLLY HILL FL 32017	FL-226*	402	14	9-17	14	36	10-56	8	38	6-62	5	40	1-68	11	36	6-54	6	50	12-78	14	14	7-51	44	20	10-35

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SOUTH MIAMI HOSP MIAMI FL 33143	27	30	14-54	15	27	16-63	63	6	3-19	16	0	0-81	247	4	3-10	98	1	1-12	20	0	0-78	299	5	3-8	176	1	0-5
SOUTH SEMINOLE COMMUNITY H LONGWOOD FL 32750	9	22	10-68	5	20	5-74	30	7	3-27	.			83	4	1-11	49	8	2-18	3	0	0-100	49	2	1-16	55	2	0-13
SOUTH SHORE HOSP MEDICAL MIAMI BEACH FL 33139	9	56	10-68	10	40	20-76	29	17	4-30	.	.		91	3	3-15	43	9	3-24	2	0	0-100	117	3	3-12	37	8	1-18
SOUTHEASTERN MEDICAL CENTE MIAMI FL 33162	21	52	15-59	20	50	22-65	28	7	3-29	5	0	0-100	92	7	3-15	79	11	6-21	4	0	0-95	90	4	2-13	69	1	0-11
SOUTHWEST FLORIDA REGIONAL FORT MYERS FL 33901	33	18	7-43	29	34	22-59	87	8	5-19	132	1	0-6	520	4	3-8	286	3	1-10	44	0	0-44	858	4	3-7	393	1	1-4
ST ANTHONY'S HOSP INC SAINT PETERSBURG FL 33705	29	24	10-48	32	19	21-56	171	9	4-14	22	0	0-79	431	6	3-9	191	4	2-11	41	0	0-18	280	6	3-9	349	2	1-4
ST AUGUSTINE GENERAL HOSP- SAINT AUGUSTINE FL 32084	17	29	10-56	10	40	11-65	17	6	2-35	2	0	0-100	87	8	1-11	60	7	2-17	9	0	0-100	73	5	1-13	28	0	0-34
ST CLOUD HOSP SAINT CLOUD FL 32769	2	0	4-93	5	20	6-76	31	10	3-27	.	.		91	4	2-12	59	3	1-16	3	0	0-100	96	2	2-12	61	0	0-11
ST FRANCIS HOSP INC MIAMI BEACH FL 33141	17	18	8-53	12	0	18-70	86	9	5-19	20	0	0-72	220	5	4-11	83	5	1-14	12	0	0-100	355	7	4-9	147	3	1-8
ST JOSEPH HOSP OF PORT CHA PUNTA GORDA FL 33952	10	20	6-61	13	38	16-66	42	5	3-24	5	0	0-100	165	5	2-10	79	3	1-14	46	0	0-88	164	2	2-9	126	2	0-7
ST JOSEPHS HOSP TAMPA FL 33677	34	21	13-49	87	45	23-48	121	7	5-17	113	0	0-9	556	4	3-8	223	5	1-10	24	0	0-74	658	3	3-7	344	2	0-4
ST LUKES HOSP JACKSONVILLE FL 32216	14	7	3-49	13	46	20-71	28	11	4-30	6	0	0-100	116	6	2-12	54	6	1-16	19	0	0-92	292	5	2-7	162	1	0-6
ST MARYS HOSP WEST PALM BEACH FL 33407	25	32	14-54	28	43	22-60	84	4	3-16	58	2	0-18	257	2	3-9	171	2	1-10	12	8	0-69	284	5	3-9	191	0	0-5
ST VINCENTS MEDICAL CENTER JACKSONVILLE FL 32204	39	8	10-44	60	37	24-51	93	5	4-17	122	0	0-7	359	5	3-9	155	3	3-13	39	3	0-28	551	5	3-7	243	0	0-5
SUN COAST HOSP INC LARGO FL 33540	16	56	9-55	18	56	14-57	54	9	4-22	8	0	0-100	173	8	3-11	137	16	4-16	15	0	0-97	164	4	2-9	136	1	0-7
SUWANNEE CO HOSP INC LIVE OAK FL 32060	11	45	7-59	2	50	3-91	.	.		.	.		23	4	1-26	11	0	1-45	.	.		56	4	1-14	3	33	0-100
TALLAHASSEE COMMUNITY HOSP TALLAHASSEE FL 32308	3	0	1-82	13	38	16-66	24	0	1-27	5	0	0-100	119	3	2-11	38	13	2-21	10	0	0-100	95	1	2-12	70	1	0-11
TALLAHASSEE MEMORIAL REG M TALLAHASSEE FL 32304	39	13	8-41	51	55	24-54	121	12	5-18	32	0	0-48	285	6	3-10	194	4	1-10	45	0	0-18	528	8	3-7	232	2	0-5
TAMPA BAY COMMUNITY HOSP TAMPA FL 33611	4	50	4-79	3	0	4-84	16	19	2-37	1	0	0-100	34	6	1-20	14	7	0-38	1	0	0-100	26	0	0-23	19	5	0-51
TAMPA GENERAL HOSP TAMPA FL 33606	74	4	3-32	10	50	12-67	30	20	1-24	8	0	0-100	118	9	3-12	69	4	1-15	18	0	0-93	755	6	4-7	131	1	0-7
TARPON SPRINGS GENERAL HOS TARPON SPRINGS FL 33589	6	33	5-71	20	65	20-63	68	9	3-18	53	0	0-38	277	6	3-9	205	8	2-11	22	0	0-86	173	1	2-9	152	3	0-6
THE BEACHES HOSP JACKSONVILLE FL 32250	6	17	5-71	6	17	6-70	18	6	2-35	1	0	0-100	68	4	1-13	28	4	1-24	7	0	0-100	65	5	1-12	20	10	0-33
TOWN COUNTRY HOSP TAMPA FL 33615	3	0	0-83	11	36	13-65	23	0	1-28	2	0	0-100	81	4	1-12	48	0	1-18	4	0	0-100	49	2	1-15	66	0	0-12
UNIVERSITY COMMUNITY HOSP- TAMPA FL 33612	28	29	11-49	21	43	19-60	76	9	3-17	178	1	0-5	250	6	3-10	148	3	1-11	15	7	0-98	244	7	3-8	213	5	0-5
UNIVERSITY GEN HOSP OF SEM SEMINOLE FL 33542	15	33	10-58	12	50	13-64	22	18	3-34	1	0	0-100	125	4	3-13	36	8	1-21	9	0	0-100	116	3	2-11	107	3	0-8
UNIVERSITY HOSP HOLLY HILL FL 32017	19	16	13-57	4	50	9-85	2	50	0-92	.	.		39	5	2-21	33	6	3-25	2	0	0-100	23	4	1-26	34	3	0-19

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
UNIVERSITY HOSP PENSACOLA FL 32501	FL-227*	389	4	3-11	14	14	4-45	5	60	4-72	5	20	2-68	18	0	8-46	2	100	2-90	5	0	0-73	19	5	4-39
UNIVERSITY HOSP OF JACKSON JACKSONVILLE FL 32209	FL-228	1330	11	6-13	125	15	13-32	32	22	11-41	23	22	7-40	34	18	10-38	34	47	22-54	34	29	5-33	110	20	11-27
UNIVERSITY OF MIAMI HOSP & MIAMI FL 33136	FL-229	226	12	8-19	31	39	18-52	2	50	3-91	15	13	8-51	4	0	3-76	1	100	1-97	.	.		8	25	6-62
US NAVAL HOSP JACKSONVILLE FL 32214	FL-230*	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VA HOSP LAKE CITY FL 32055	FL-231*	1	100	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.		
VALLEY SPRINGS COMMUNITY H DE FUNIAK SPRINGS FL 32433	FL-232*	372	15	9-18	12	67	18-70	15	13	12-56	9	22	2-52	24	17	9-42	7	43	20-83	15	27	5-47	41	24	12-38
VENICE HOSPITAL INC VENICE FL 33595	FL-233	4650	10	10-16	561	21	17-31	193	19	22-36	132	8	9-25	224	24	18-30	243	35	32-47	85	13	9-30	299	15	14-26
VICTORIA HOSP INC MIAMI FL 33128	FL-234*	1226	10	7-14	105	29	15-35	23	30	14-51	26	12	7-39	51	27	15-39	34	50	25-57	20	20	7-44	86	14	13-32
WALKER MEMORIAL HOSP- AVON PARK FL 33825	FL-235*	1497	10	8-15	101	30	17-37	70	39	18-40	33	9	6-33	63	19	13-35	46	33	25-53	64	17	6-29	123	13	13-29
WASHINGTON CO HOSP CHIPLEY FL 32428	FL-236*	502	9	9-17	8	38	6-63	15	40	11-54	9	0	5-57	53	4	11-33	20	45	20-61	22	9	6-41	78	12	11-30
WATERMAN MEDICAL CTR EUSTIS FL 32726	FL-237*	2144	13	9-15	179	11	12-28	106	29	19-37	70	11	8-28	127	29	17-33	60	38	26-52	72	26	11-34	172	27	15-29
WELLINGTON REGIONAL MEDICA WEST PALM BEACH FL 33414	FL-238	160	13	9-21	8	25	10-68	9	33	8-62	3	0	1-81	15	33	12-55	7	43	12-74	5	40	8-78	9	22	7-60
WEST BOCA MEDICAL CENTER BOCA RATON FL 33428	FL-239	709	8	8-16	38	29	12-41	27	11	14-48	12	0	3-47	40	23	13-39	49	29	25-52	9	0	2-53	60	8	10-31
WEST FL REGIONAL MEDICAL C PENSACOLA FL 32504	FL-240	2948	10	8-14	210	20	16-33	115	21	19-36	35	29	8-35	124	25	15-31	90	34	27-48	47	19	9-36	141	21	14-29
WEST ORANGE MEMORIAL HOSP- WINTER GARDEN FL 32787	FL-241*	668	9	7-15	33	12	11-42	13	8	10-57	8	25	1-55	33	18	10-38	16	38	18-63	45	13	6-31	83	23	11-29
WEST VOLUSIA MEMORIAL HOSP DE LAND FL 32720	FL-242*	1336	12	8-15	101	38	16-36	74	27	18-39	28	21	6-36	71	23	13-33	61	38	25-50	26	4	5-37	91	15	9-26
WESTCHESTER GENERAL HOSP- MIAMI FL 33155	FL-243*	269	4	7-16	12	0	6-53	3	0	3-83	3	0	1-82	11	18	10-61	5	40	17-88	6	0	3-66	22	5	6-40
WILLISTON MEMORIAL HOSP IN WILLISTON FL 32696	FL-244*	382	18	12-21	18	28	10-51	20	50	15-55	4	0	1-74	48	29	11-34	33	30	20-52	17	35	6-46	42	26	12-38
WINTER HAVEN HOSP WINTER HAVEN FL 33880	FL-245*	3954	11	9-15	357	23	18-32	177	23	20-34	93	11	8-26	174	16	15-29	162	34	29-46	126	13	9-28	307	18	14-26
WINTER PARK MEMORIAL HOSP- WINTER PARK FL 32792	FL-246	3180	10	7-13	245	16	14-30	92	34	19-39	65	8	9-31	149	26	16-30	77	43	26-49	87	20	10-31	211	19	13-26
WUESTHOFF MEMORIAL HOSP- ROCKLEDGE FL 32955	FL-247*	2327	10	8-14	182	26	15-32	78	31	19-40	26	19	5-35	122	18	15-31	68	44	28-52	31	16	7-38	179	13	13-27

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
UNIVERSITY HOSP PENSACOLA FL 32501	4	0	1-76	3	67	7-88	1	0	0-99	.	.		20	0	0-29	8	13	0-54	.	.		15	0	0-35	63	0	0-15
UNIVERSITY HOSP OF JACKSON JACKSONVILLE FL 32209	36	11	3-37	13	54	13-62	34	15	2-23	6	0	0-99	74	4	1-13	64	8	1-15	12	0	0-99	97	1	1-10	49	4	0-17
UNIVERSITY OF MIAMI HOSP & MIAMI FL 33136	2	50	6-95	.	.		.	.		.	.		62	3	2-16	2	0	0-97	.	.		1	0	0-97	6	0	0-75
US NAVAL HOSP JACKSONVILLE FL 32214	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VA HOSP LAKE CITY FL 32055	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VALLEY SPRINGS COMMUNITY H DE FUNIAK SPRINGS FL 32433	9	33	8-65	2	50	3-91	4	25	0-75	.	.		31	6	1-22	28	11	2-26	4	0	0-100	43	5	1-17	10	0	0-88
VENICE HOSPITAL INC VENICE FL 33595	13	15	8-58	44	18	22-53	130	9	5-17	24	0	0-79	427	6	3-8	227	4	2-10	61	0	0-27	441	2	3-7	310	2	1-4
VICTORIA HOSP INC MIAMI FL 33128	10	10	8-63	8	13	10-69	24	13	3-30	14	0	0-93	153	6	2-10	62	2	1-15	8	0	0-96	64	6	1-13	104	0	0-8
WALKER MEMORIAL HOSP- AVON PARK FL 33825	9	11	4-59	19	11	13-55	37	3	2-22	.	.		159	4	2-9	94	2	1-13	26	0	0-71	169	1	2-9	57	2	0-14
WASHINGTON CO HOSP CHIPLEY FL 32428	8	13	3-61	1	0	2-98	3	0	1-81	.	.		56	4	2-16	23	13	2-30	3	0	0-100	60	2	2-15	9	0	0-95
WATERMAN MEDICAL CTR EUSTIS FL 32726	16	38	6-51	13	31	16-66	94	7	3-16	7	0	0-100	272	4	3-9	153	3	1-11	23	0	0-46	159	3	2-9	99	1	0-8
WELLINGTON REGIONAL MEDICA WEST PALM BEACH FL 33414	.	.		1	100	1-97	4	0	1-74	1	0	0-100	17	0	0-33	7	29	0-58	2	0	0-100	19	0	1-30	12	0	0-88
WEST BOCA MEDICAL CENTER BOCA RATON FL 33428	7	14	7-70	5	20	7-77	18	6	2-34	1	0	0-100	62	0	1-13	25	12	1-26	9	0	0-98	119	1	1-10	31	0	0-25
WEST FL REGIONAL MEDICAL C PENSACOLA FL 32504	33	30	9-45	32	38	23-58	64	17	4-21	63	2	0-15	240	3	3-10	104	6	1-13	23	0	0-50	371	6	3-8	211	1	1-5
WEST ORANGE MEMORIAL HOSP- WINTER GARDEN FL 32787	2	0	0-90	4	25	7-82	13	15	1-40	.	.		78	0	1-12	43	5	1-19	5	0	0-100	73	4	1-12	42	0	0-18
WEST VOLUSIA MEMORIAL HOSP DE LAND FL 32720	5	20	2-71	5	0	7-77	44	9	3-23	2	0	0-100	135	4	2-11	36	0	1-21	15	0	0-100	112	3	2-12	143	2	0-6
WESTCHESTER GENERAL HOSP- MIAMI FL 33155	2	0	0-93	2	100	7-95	1	0	0-99	.	.		29	7	3-28	8	0	0-57	2	0	0-100	28	4	1-23	51	0	0-13
WILLISTON MEMORIAL HOSP IN WILLISTON FL 32696	2	0	2-91	12	33	13-64	.	.		.	.		43	2	1-17	10	0	2-48	4	0	0-100	39	0	1-18	3	0	0-99
WINTER HAVEN HOSP WINTER HAVEN FL 33880	42	29	13-47	69	39	23-50	127	7	4-16	19	0	0-92	381	2	2-8	270	2	1-9	51	0	0-48	314	3	2-7	240	1	0-5
WINTER PARK MEMORIAL HOSP- WINTER PARK FL 32792	10	30	6-60	25	16	19-57	111	15	4-17	17	0	0-98	392	3	2-7	204	1	1-10	41	0	0-48	213	6	2-8	327	2	0-4
WUESTHOFF MEMORIAL HOSP- ROCKLEDGE FL 32955	26	12	13-52	26	35	24-63	63	5	3-18	8	0	0-99	229	1	3-9	113	0	1-12	31	0	0-84	185	3	2-9	191	2	0-5

*Written Comments Not Submitted.

ALACHUA
GENERAL HOSPITAL, INC.
A SANTAFE HEALTHCARE CENTER
801 S.W. Second Avenue Gainesville, Florida 32601-6298 (904) 372-4321

October 26, 1987

Health Care Financing Administration

For release with publication of
Medicare Mortality information.

ALACHUA GENERAL HOSPITAL, INC. has reviewed the Medicare mortality information published by the Health Care Financing Administration (HCFA), and we found no significant errors in the data. We understand the mortality information submitted by HCFA only includes Medicare patients served by ALACHUA GENERAL HOSPITAL.

The Board of Directors, Medical Staff, and Administration of ALACHUA GENERAL HOSPITAL, INC. are pleased to see that all of the mortality rates for our hospital are well within the ranges set by the Health Care Financing Administration, even with our wide range of services offered to this community. ALACHUA GENERAL HOSPITAL recognizes that the continuation of our standard of quality will be based on our systematic approach to the assessment of quality within the hospital rather than the study of one variable which may change drastically from year to year through simple statistical variations.

The following information about ALACHUA GENERAL HOSPITAL, INC. will help to reaffirm our history of providing quality health care and assure our patients and the community of our continued commitment to monitor quality services now and in the future.

ALACHUA GENERAL HOSPITAL, INC. is a 506-bed, not-for-profit, full service community hospital serving the Gainesville and surrounding North Florida areas since 1928. The major services include general acute care, emergency, cardiac treatment, cancer treatment, obstetrics, medical and surgical intensive care units, Hospice, and helicopter emergency services. The hospital has a medical staff made up of all the major specialties and subspecialties, and a complete staff of primary care physicians serving a wide population base.

Many of the services offered by ALACHUA GENERAL HOSPITAL attract patients who are critically ill or referred for advanced levels of treatment available through the hospital's medical staff. For example, ALACHUA GENERAL HOSPITAL is a receiving hospital for complex medical cases referred from outlying hospitals. In addition, our helicopter service brings in accident trauma patients to the Emergency Department and severely ill heart patients for our cardiac treatment program. The Level II Emergency Department receives 57 percent of all patients transported by the county ambulance service. Additionally, the Hospice program, which cares for the terminally ill may attract more severely ill patients than a hospital without such a program. Fifty-one percent (51%) of all patients in Alachua County requiring hospitalization are admitted to ALACHUA GENERAL HOSPITAL.

As a full-service, not-for-profit community hospital, ALACHUA GENERAL HOSPITAL provides more than $4,233,000 in uncompensated care (excluding bad debts) to a broad population both in the hospital's immediate and surrounding service area.

To best assure our patient population of our commitment to quality of service, ALACHUA GENERAL HOSPITAL has in place a comprehensive quality assurance monitoring program accredited by the Joint Commission on Accreditation of Hospitals. Our quality assurance program monitors all patients treated by the hospital, including a review of every death occurring within the hospital. Staff physicians screen hundreds of quality indicators on a regular basis as a means to evaluate the care provided to our patients. This systematic approach to the assessment of quality care results in a consistent level of quality within the hospital. The singular and simple evaluation of mortality data as the only assessment of quality is considered to be inappropriate since such mortality rates may fluctuate considerably from one period to another for any particular hospital.

ALACHUA GENERAL HOSPITAL, INC.
801 Southwest Second Avenue
Gainesville, Florida 32601

AMI Kendall Regional Medical Center
11750 Bird Road, Miami, Florida 33175-3530, (305) 223-3000

October 28, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Washington, D.C. 20201

RE: HCFA Mortality Data

Dear Dr. Roper:

This is in response to your request for comments concerning the Mortality Data to be released for AMI Kendall Regional Medical Center, facility number 10-0209. We have reviewed the data submitted and have been unable to determine that all of the deaths attributed to AMI Kendall have received services at our facility during fiscal year 1986. In addition, we have noted that we are unable to confirm that death occurred in all cases within 30 days of hospital admission. Also, we cannot verify that AMI Kendall was the last facility at which inpatient care was rendered.

The information which has been provided will be utilized by our facility and incorporated into our ongoing quality evaluations of the care we provide. We appreciate having the opportunity to comment prior to the publication of this information.

Sincerely,

Victor J. Maya
Executive Director

cc:Eve-Ellen Mandler, RRA

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

AMI KENDALL REGIONAL MEDICAL CENTER
11750 Bird Road, Miami, Florida 33175-3530, (305) 223-3000

MEMORANDUM

To: **John J. Silver, Jr.**
Group Vice President

Date: **9/25/87**

From: **Victor J. Maya**
Executive Director

cc. **Lidio Mora, M.D.**
Chiefs of Departments
Board Meeting

Subject: **HCFA Mortality Data**

As you may be aware, in December 1987 the Health Care Financing Administration will be publishing selective mortality information for acute care hospitals treating Medicare patients in 1986. This information will be made available to peer review organizations to determine if problems in the quality of care exists in certain institutions. In addition, this information will be offered to physicians, professional societies and consumers so that their selection of hospital care can be, in part, based on the performance of the institution as reflected through their mortality rates.

A copy of the mortality data for AMI Kendall Regional Medical Center is attached for your review. We are pleased to advise you that our facility has rated well within the predicted mortality rates for each category as well as all Medicare cases. We therefore will not be forwarding any additional, supplemental information to HCFA concerning this information prior to its publication in December. Because our results are good, we also plan to utilize this information in our efforts to solicit support from our Medical Staff as well as in our negotiations with purchases of health care.

We are very pleased to advise you of this and would appreciate your sharing this information with others as you see appropriate.

VJM:SMK:aml

Enclosures

AMI North Ridge Medical Center

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
P. O. Box 26684
Baltimore, Maryland 21207

RE: Medicare Provider No. 100237

Dear Doctor Roper:

In response to the recent mortality information relating to North Ridge Medical Center, I would like to offer the following information that would be of interest relating to these statistics.

For one, North Ridge Medical Center is a referral center for cardiology. Therefore, the Hospital receives numerous transfers from other institutions. This is primarily attributed to the fact that our Hospital specializes in the treatment of heart disease and has special emphasis on cardiac surgery.

During 1985 and 1986, North Ridge Medical Center had the second highest case mix index in the State of Florida as reported by the Health Care Financing Administration. In addition, North Ridge had the highest case mix index in South Florida. As you are well aware, case mix index is an indicator that measures the severity of illness of those patients admitted to our Hospital and compares this with other facilities.

We are pleased that our mortality rates in every one of the sixteen diagnostic categories are within the predicted range. This is extremely important as our case mix index is very high.

If you have any additional questions, please do not hesitate to contact me.

Sincerely,

Don S. Steigman
Executive Director

DSS/lb

BASCOM PALMER EYE INSTITUTE

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF OPHTHALMOLOGY

P.O. BOX 016880/ MIAMI, FLORIDA 33101/U.S.A.
TELEPHONE: (305) 326-6325

September 28, 1987

William L. Roper, MD
Administrator
Department of HHS
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper;

After review of the mortality data recently recieved from your Health Standards and Quality Bureau, I would submit the following comments.

Your method of merging information reported from Social Security Administration with the last submitted UB 82 for Medicare payment is not only misleading but also inaccurate. It makes no provision for situations where ederly patients are transported from Long-Term Medical facilities to Specialized Acute Care facilities for specific care which is not related to chronic medical contitions which cause death. Misleading reporting of this nature decreases quality of care and denies quality of life to our elderly.

Mortality reporting may be an excellent generic screen to utilize in public educationand teach the quality indicator concept but it can be easily misinterperated. Generic Screening is only effective when all factors are considered and sound criteria development utilized. Perhaps your methodologies need refinement for your reporting to be productive.

Thank you for the opportunity to comment. I hope that in the future we will be given opportunity to assist in the development stage to assure a quality product.

Sincerely,

Carol Robertson, RN

Carol Robertson, RN
Director, Quality Assurance

ANNE BATES LEACH EYE HOSPITAL
900 N.W. 17th Street

WILLIAM L. McKNIGHT VISION RESEARCH CENTER
1638 N.W. 10th Avenue

A private, independent, international university An equal opportunity / affirmative action employer

BAPTIST HOSPITAL
OF MIAMI

COMMENTS ON THE HCFA MORTALITY DATA

Baptist Hospital of Miami
8900 North Kendall Drive
Miami, Fl. 33176
Medicare Provider Number 100008

The 1986 data used by HCFA indicate that 238 Medicare patients died within 30 days of admission to Baptist Hospital of Miami. Of these, 193 died while still a patient in the hospital, while 45 died after discharge. Comparison of the hospital's records with HCFA's data indicate that the number of deaths occurring while in the hospital for the specified diagnostic categories is accurate. However, it is difficult to determine accurately whether, in fact, the remaining patients did die after discharge from Baptist Hospital, or, more importantly, what the actual cause of death was for those dying after discharge. While we do have control over the quality of care provided in the hospital setting, we do not have control over the care a patient receives outside of the hospital. Factors such as family, income level, environment, physical condition and follow-up medical attention play a major role in the outcome of a patient's illness.

While we support HCFA's intent--to offer a method of measuring a health care facility's quality of care-- we object to certain assumptions made in determining acceptable mortality rates for the various diagnostic categories. This includes the assumption that the quality of care rendered in the hospital setting necessarily impacts the patient's survival once discharged from the hospital.

The hospital is also concerned about the lack of qualifying statements regarding the case mix of a given institution. While Baptist Hospital appreciates the opportunity to comment about the HCFA mortality rates, the average consumer may not have the opportunity to review the comments made. Interpretation of the data will be made for the consumer primarily by the news media. While responsible journalists will strive to accurately reflect the data and comments made, it is difficult to provide readers with all of the information necessary to reach informed conclusions regarding the quality of their health care institution.

Baptist Hospital fared well in the HCFA release of mortality rates, with all 16 of the diagnostic categories reflecting a rate within the predicted range of mortality rates. However, we believe comments are necessary for two of those categories: cancer and severe acute heart disease.

8900 North Kendall Drive
Miami, FL 33176-2197
(305) 596-1960

Cancer

Baptist Hospital is the only facility between the City of Miami and Key West offering the three primary types of cancer treatment--radiation therapy, chemotherapy and surgery. According to the latest statistics available from the Florida Cancer Data System (1985), Baptist served the second highest number of cancer inpatients, 1,189, topped only by Jackson Memorial Hospital, 1,647. As a major cancer treatment facility, Baptist attracts patients at various stages of disease, ranging from those treated with a curative intent, to those treated with palliative intent only (minimizing/controlling uncomfortable and painful symptoms).

Because of the high degree of sophistication of cancer care at Baptist Hospital, Baptist attracts some of the most difficult of cancer cases in Dade and Monroe counties. Despite the severity of our case mix (at least 80 percent of the cancer patients included in the HCFA mortality data for Baptist were admitted in the final stages of what is generally considered to be terminal illness), our cancer mortality rate among our Medicare population, 34 percent, falls well within HCFA's predicted 21-38 percent range. Furthermore, Baptist Hospital prides itself on the quality of medical and support services offered to cancer patients, including expertise in pain management, psychological support to patients and their families, and the home care of the cancer patient.

Of the 79 Medicare patients who died of their cancer, 63 did so while in the hospital--25 within the first three days of admission--and 16 died after discharge. These figures are indicative of two trends in caring for cancer patients. Many families admit their loved ones to the hospital setting when death is imminent. Conversely, an ever-increasing number of cancer patients choose to die at home.

Severe Acute Heart Disease

Nationally, the number of deaths attributed to acute heart disease is approximately two and one half times the number of deaths attributable to cancer and nearly 10 times the number caused by trauma. Of those people suffering a myocardial infarction in 1987, approximately 36 percent died--50 percent within the first two hours after the onset of symptoms, according to the American Heart Association. Those who make it to a hospital improve their odds for survival, but how much those odds improve depends on many factors not in the control of the hospital, such as the amount of time lapsed between the onset of symptoms and arrival in the medical setting; first aid rendered; and the overall health of the person.

The impact of these national statistics are felt at Baptist where 34 Medicare patient deaths in 1986 were related to severe acute heart disease--placing the hospital's actual mortality rate midway in the range of HCFA's predicted mortality rates. Of those deaths, 28 of the patients were admitted through the hospital's Emergency Center and two were transferred from another facility, an indication of the severity of the condition of nearly 90 percent of the patients in this category. Six of the patients admitted with severe acute heart disease died on the day of admission; 19 died within three days of admission, another indication of the severity of their condition.

As the busiest Emergency Center in South Dade County, Baptist Hospital expects to receive on an emergency basis a large number of people suffering from severe acute heart disease. In response to this, our Emergency Center physicians and nurses and the cardiologists on staff have joined together to provide the most medically appropriate and intense response available in an effort to improve the survival rates of patients suffering from acute heart disease.

In Conclusion

HCFA data is helpful to institutions for their own internal review. At Baptist, such data will be utilized as a supplement to the extensive Quality Assurance mortality review procedures already in place. It should be stressed, however, that mortality data--alone--is not an indicator of the quality of care and should not be interpreted as such.

###

STEPHEN D. MASON
Administrator

BARTOW MEMORIAL HOSPITAL
1239 E. MAIN STREET
POST OFFICE BOX 1050
BARTOW, FLORIDA 33830
PHONE 813-533-8111

October 27, 1987

Mr. Harvey Brook
HCFA-HSQB
Hospital Mortality Information
Room 2D-2, Meadows East Bldg.
6300 Security Blvd.
Baltimore, Maryland 21207

RE: Selected Mortality Information for Calendar Year 1986
for Medicare Patients Admitted to Hospital No. 10-0121

Dear Mr. Brook:

First, publishing information based on statistics which are so questionable is highly irresponsible. The major error we have discovered in this data is that instead of 329 cases as you report, there were actually 506 Medicare discharges for this period of time. Therefore all of the mortality percentages as originally reported are substantially inflated.

We strongly feel that statistics of this nature should not be published at all. The numbers by themselves are meaningless without clinical information to aid in interpretation. Uninformed persons may draw conclusions from this data that are totally erroneous.

We know that the quality of acute care by physicians and staff at Bartow Memorial Hospital is on the whole excellent. One value we have derived from this data is that it has given us a new way to look for trends in our quality assurance program in order that we may improve our quality of patient care.

Sincerely,

Stephen D. Mason
Administrator

Attachments

	HRS			BMH		
Category	#Cases	#Deaths	Rate	#Cases	#Deaths	Rate
All	329	37	11%	506	*	7%
CA	20	4	20%	23	*	17%
CE	12	6	50%	16	*	37%
GC	13	2	15%	16	*	12%
GI	50	1	2%	80	*	1%
GU	17	0	0%			
GY	5	0	0%			
HL	23	0	0%			
HM	27	8	30%	35	*	22%
HS	10	5	50%	27	*	18%
ME	14	2	14%	19	*	10%
OP	17	0	0%	47	*	
PN	23	2	9%			4%
RN	4	0	0%	1	*	100%+
SE	2	0	0%			
TR	9	2	22%			
UN		5				

Statistical Variance HRS data versus BMH data

Note:
-- variances in the number of MC discharges
-- * for # deaths use HRS info, unverifiable due to inclusion of deaths after discharge.
-- + percentage consists of only one patient in this category.
-- HRS actual mortality rates includes the number of patients who died within 30 days of discharge. The death outside of the hospital may not be related to condition the patient was in the hospital form; and may not be related to the diagnostic category indicated by HRS.



BAY
MEDICAL
CENTER

October 27, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

We have reviewed the data provided by you on mortality information about Medicare patients treated in Bay Medical Center in 1986. After our review, we were very pleased to verify that all mortality percentages at Bay Medical Center were well within normal limits. Our staff, however, found a few discrepancies that we would like to bring to your attention. We acknowledge that most of the discrepancies are probably elements of minimal significance, but also feel that all elements should be correct in order to have a high level of confidence in the total statistical picture.

The first element that was noted as inconsistent was the HIC number. Twenty-five numbers were noted to have inconsistent lettering or numbering. The age of patients was noted to be inconsistent with our records on twenty-six cases. Date of death or discharge was discrepant in ten cases. Four diagnosis codes and one procedure code was noted as inconsistent.

A major inconsistency noted was that our records do not reflect the admission to our facility of one of the patients who subsequently expired. Patient identity taken from the listing provided by your department is noted on our enclosure.

Of particular significance in the data is that all patients who died within thirty days of discharge were included. Patients who die of causes unrelated to their hospitalization, such as accidental deaths, are included in this calculation and may skew the result. The patient who has a terminal disease process, regardless of its stage, is also included in this calculation, and this fact would appear to inaccurately reflect on the facility statistics.

The public should be given a clear understanding of the implications of this data. A statistically significant sample should be used if percentage data is to be published. This data should not be used alone to interpret health care quality. We therefore request that you furnish all final documents to us prior to their publication to completely assure the public of having accurate data.

We believe that the public should be informed about the quality of health care in all facilities. Our desire is to assist in public education in this regard to assure that a realistic and total picture is presented to the consumer. The complexity of services offered only at Bay Medical Center in our area draws a high volume of critically ill patients. We want to communicate the effect this has on raising mortality statistics and make sure the public is aware of this fact. Numbers alone cannot adequately present a picture of quality care.

Sincerely,

A. Gary Muller, FACHE
Administrator

AGM:dlw

Enclosure

Provider #10026

DATA DISCREPANCIES

HIC #	= 25
AGE	= 26
DEATH/DISCHARGE DATE	= 10
DIAGNOSIS CODE	= 4
PROCEDURE CODE	= 1

**One death listed as occurring in this facility cannot be verified as an admission to this hospital. Cross-checks of admit/discharge logs, MPI and Morgue log verify that this patient was not in Bay Medical Center at the time noted. Information as you provided:

Patient ID Number (HIC)	Surname (First 6 LTRS)	Diagnostic Category
[redacted]	[redacted]	CE

Age	Sex	Date of Adm.
078	F	06/03/86

Date of Discharge	Principal Diagnosis
06/12/86	431

BETHESDA
MEMORIAL
HOSPITAL

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

RE: MORTALITY RATES, HOSPITAL I.D. #100002

Dear Dr. Roper:

After reviewing the mortality information supplied by HCFA, we would like to make the following comments for inclusion in any media releases:

> Health Care Financing Administration has not provided information regarding the construction of the mortality ranges as they are reported. While we do not understand the construction, the reports of deaths at Bethesda Memorial Hospital is consistent with hospital records. We do believe, however, that the death rate is skewed due to the presence of data on patients who died immediately after admission.
>
> For example, in diagnostic category HM (severe chronic heart disease) the mortality rate, excluding one-day stays, would have been 14 percent instead of the reported 36 percent. In diagnostic category ME (metabolic/electrolyte disturbances) the rate would have been 37 percent instead of 42 percent.

We appreciate the opportunity to respond to this data prior to its release.

Sincerely,

Robert B. Hill

Robert B. Hill
President

2815 South Seacrest Blvd.
Boynton Beach, FL 33435
Tel.: (305) 737-7733

BRADFORD HOSPITAL, INC.

October 14, 1987

Department of Health & Human Services
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

After reviewing the mortality data you sent out September 21, 1987, I have found only one error. Patient number [redacted] was hospitalized again at Bradford Hospital on November 3, 1986. She subsequently expired on November 11, not November 7, as reported in your data. Her principal diagnosis was bilateral broncho-pneumonia (482.3) not 535.0. I have attached a corrected copy of the information that you need for your report.

Thank you for your attention in this matter.

Sincerely,

Jim Rearick

Timothy H. Rearick
Administrator
Chief Operating Officer

THR/vl

cc: Jan Jughey

Attachment

922 East Call Street / Starke, Florida 32091 / (904) 964-6000

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Bradford Hospital

Pt ID #	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Principal Diagnosis	Principal Procedure
[redacted]	[redacted]	PN*	081	F	11-03-86	11-11-86	11-11-86	482.3	

* Data underlined is corrected data

FL 32.1

AMI Medical Center
Orlando
1800 Mercy Drive • Orlando, Florida 32808 • (305) 295-5151

October 27, 1987

William Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Re: Mortality Statistics - Provider No. 100129
January 1986 - December 1986

Dear Dr. Roper:

We appreciate the opportunity to respond to the release of data on hospital mortality rates for January 1986 through December 1986. Since receiving the report dated September 21, 1987, AMI Medical Center Orlando (AMI-MCO) staff has had an opportunity to review the data. Based on our comprehensive review of the data and the specific medical records it reflects, we are confident that you and any member of the public who requests a copy of our statistical information will be interested in our summary report.

CA-Cancer. The predicted percentage of deaths in this category was 13-36%. Our actual mortality rate was 11% or 7 of 66 patients. Six of the patients expired in the hospital with an average stay of 6.7 days. All were admitted with a poor prognosis and other complications. One patient expired at home seven days after discharge. All seven patients and/or their families had requested "do not resuscitate" during hospitalization.

CE-Cerebrovascular Accidents. The predicted percentage of deaths was 14-49%. Our actual mortality rate was 38% or 10 of 26 patients in this high risk category. The average length of stay for the nine patients who expired while hospitalized was 2.6 days. In all but two cases, the family/patient requested "do not resuscitate." The one patient who expired after discharge was received from a nursing home and transferred back where he expired one week later.

EY-Ophthalmologic Disease. The predicted mortality rate was 0-100% with our actual rate being 33% or one of 3 patients. This one patient had a retinal artery occlusion as well as other cerebrovascular conditions. She expired after transfer to a nursing home at age 88.

GC-Gastrointestinal Catastrophes. The predicted percentage of deaths was 7-40% with our actual rate of 8% or 2 of 24 cases. Both patients were admitted through the emergency room. One patient had metastatic carcinoma of the gastrointestinal tract and renal failure. The second patient expired three days after surgery to remove the infected bowel.

GE-Gastrointestinal Disease. The predicted mortality rate was 2-12%; our rate being 5% or 5 of 104 cases. The average age of all five patients was 86 years old. Of the two patients who expired after discharge, one had metastatic cancer and expired after being brought to the emergency room from home, the other patient had heart failure and expired in a nursing home.

GI-Urologic Disease. The predicted mortality rate was 2-19%; our actual was 9% or 5 of 54 patients. One patient actually expired in 1987 and one could not be verified either through the physician or nursing home transferred to on discharge from our facility. Of the three who expired while hospitalized, all were "do not resuscitate" at the request of the patient/family. All three were transferred here from a nursing home setting.

GY-Gynecologic Disease. Predicted rate of 0-98%; ours was 0%.

HL-Low Risk Heart Disease. The predicated percentage of deaths was 2-13% with our actual rate being 4% or 3 of 81 patients. The two deaths after discharge could not be verified with the attending physician or nursing home. Average age of all three patients was 81, all with other body system failures.

HM-Severe Chronic Heart Disease. The predicted death rate was 12-35%; our actual was 15% or 8 of 52 patients. All eight expired while hospitalized with an average length of stay of 10.8 days. In addition to the chronic heart disease, all had at least one body system failure such as respiratory failure or renal failure. Average age of these patients was 80 years old.

HM-Severe Acute Heart Disease. The predicted death rate was 23-55%; our actual was 57% or 21 of 37 cases. One patient expired at home after discharge from a hospitalization of 15 days. Half of the patients were admitted to the hospital with cardiorespiratory arrest occurring at home. The patient/family requested "do not resuscitate" in 55% of the cases. Admissions through the emergency room accounted for 90% of the patients. Only two patients were considered to have a good prognosis on admission however both developed complicating conditions.

ME-Metabolic/Electrolyte Disturbances. The predicted rate of death was 7-36%; our actual rate was 12% or 4 of 33 patients. All four patients expired in the hospital contrary to the data indicating two deaths after discharge. The average age in this category was 87. All patients had other body system failure(s) in addition to the severe dehydration causing hospitalization.

OP-Orthopedic Disorders. The predicted rate was 0-13%; our actual rate was 2% or 1 of 53 patients. This patient expired three days after discharge to home at age 81.

PN-Pulmonary Disease. The predicted mortality rates were 11-30%; our actual rate was 20% or 17 of 87 cases. Five patients expired an average of 7 days after discharge. Three expired in a nursing home, two at home. Nine were admitted from a nursing home and 13 were admitted through the emergency room. Average age was 81 years old.

RN-Renal Disease. Predicted death rate was 10-71%; our actual rate was 50% or 4 of 8 cases. Three patients were admitted from nursing homes; two patients via the emergency room. Average length of stay was 3 days, one expiring within 7 hours of admission from the nursing home. All patients had complicating conditions.

SE-Sepsis. Predicted mortality rate was 7-62% with our actual rate being 44% or 4 of 9 patients. Three were admitted from nursing homes and at the patient/family request were a "do not resuscitate" status.

In reviewing data of this nature, we must keep several factors in mind:

- Category assignment is based on the reason for admission to the hospital and not the actual cause of death.
- Patients admitted from nursing homes tend to be more critically ill than patients admitted from home.
- Statistical data (mortality rates) can offer no more than a basis for further review. Quality judgements can only be made after reviewing information in a patient's medical record.

The Medical Staff of AMI Medical Center Orlando, as has been their practice, will continue to review all mortality cases for the quality and appropriateness of care rendered to the individual patient. This type of review is only one of the many ways we endeavor to identify opportunities to improve patient care.

We appreciate the opportunity to present this response.

Sincerely,

Gary L. Rowe
Chief Executive Officer

/es

Broward General Medical Center

1600 South Andrews Avenue
Fort Lauderdale, Florida 33316
305/355-4400

October 22, 1987

Harvey Brooks
Special Assistant
Health Care Financing Administration
Health Standard & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Broward General Medical Center - Provider # 100039

Dear Mr. Brooks:

The attached is our response to the mortality rates received from H.C.F.A. Broward General Medical Center is committed to upholding its high standards for delivery of quality care to the patients we serve. We agree with Dr. William Roper, Administrator, H.C.F.A. that mortality statistics cannot be utilized as a true measure of quality care.

Mortality rates do not take into consideration the severity of the individual patient's illness, nor does it account for multiplicity of medical problems treated during an admission. Although the information published applies only to Medicare, it can create a false impression of the overall quality of care at any hospital.

The Joint Commission on Accreditation of Healthcare Organizations is presently developing a model quality of care indicator. Per JCAHO, this process will take several years inclusive of testing and is expected to produce an accurate measurement. We look forward to the completion of this project and support the JCAHO in its endeavors.

Sincerely,

Charles E. Delane
Assistant Administrator

CED:KL/pmc

A Facility of
North Broward
Hospital District

HCFA MORTALITY STUDY

Broward General Medical Center is the trauma center for our geographic location. Our Emergency Department is the second largest in South Florida. These patients are generally in a high risk category and are more seriously ill than those treated at other area hospitals. Many of the patients we treat are unknown to this hospital and/or to the physicians treating them. They may not have a family member available who could give an accurate history. In addition, Florida may be home to a patient during the winter months only.

The figures do not take into account comorbid conditions, severity of illness and frequently the actual cause of death. Events leading up to the admission are not given consideration. Without indepth study, these statistics alone do not indicate quality of care, which is monitored by other internal methods.

GENERAL INFORMATION:

After review of all patients listed in the sixteen (16) HCFA diagnostic categories, the following was determined:

- average age for all categories is 78.4 years
- 26% of the patients were admitted from an Extended Care Facility
- 8% were transferred to Broward General Medical Center from other acute facilities
- Many patients were admitted for related conditions during the twelve (12) months prior to their date of expiration.
  - 24% were admitted one time
  - 12% had two (2) admissions
  - 8% were admitted three (3) or more times
- 66% of the patients had three (3) or more comorbid conditions
- Documentation in 83% of the charts revealed the patient's prognosis was poor.
  - 61% had a DO NOT RESUSCITATE order
- Medicare guidelines expect hospitals to discharge patients who require custodial care only; therefore, death following discharge from the hospital is anticipated in many cases.
- Our actual mortality rates fell within the low to midrange of predicted mortality rates.

SPECIFIC CATEGORIES:

HIGH RISK:

CA - CANCER:

Fifty-four (54) patients with an average age of 75.3 were reviewed. Eleven percent (11%) of these patients were admitted from nursing homes. Forty-six percent (46%) had greater than three (3) comorbid conditions.

Many patients in this category were diagnosed as terminal before being discharged home with hospice care or to a nursing home for custodial care.

- Often times these patients had undergone chemotherapy and/or radiation treatment.

Our midrange mortality rate of 24% would be anticipated for this high risk category.

CE - CEREBROVASCULAR ACCIDENT:

Cerebrovascular accident, another high risk category, shows our actual mortality rate to be 26% (again, midrange of predicted rates). A better way to state this might be that "74% of the patients treated at Broward General Medical Center for a CVA, survived". Of those who expired, the average age was 78.6. Sixteen percent (16%) of the patients were admitted from nursing homes, and 56% had greater than three (3) comorbid conditions.

A number of these patients were comatose on admission to the Intensive Care Unit, placed on ventilators and never regained consciousness.

SE - SEPSIS:

Our actual mortality rate of 29% falls on the low side of the predicted range for this category. Of those who expired, 86% were admitted from an Extended Care Facility: the average age was 79.7. Sepsis is a high risk category: our success rate for these patients should receive positive comment.

ME - METABOLIC/ELECTROLYTE DISTURBANCES:

This particular high risk category identified four (4) deaths. The average age was 80. The two (2) patients who died inhouse had been admitted twice in the previous year. One patient was being treated for cancer. Our actual mortality rate was below the predicted range.

LOW RISK CATEGORIES:

Ophthalmologic Diseases, Gastrointestinal Disease, Urologic Disease, Low Risk Heart Disease, Orthopedic Disorders.

Thirty-two (32) patients were reviewed in these five (5) low risk categories. Of these, 28% expired post discharge: the cause of death could not be verified. Twenty-five percent (25%) of these patients were admitted from an Extended Care Facility.

For each of these five categories, Broward General Medical Center's actual mortality rate was on the low end of the predicted range.

In addition we had 0% mortality rate for diagnostic category Gynecologic Diseases.

EXPIRATIONS POST DISCHARGE:

Of the sixty-four (64) expirations following discharge, we did make contact with the attending physicians for fifty (50) cases.

We found it almost impossible to verify the dates of death post-discharge for several reasons. Patients who present to the Emergency Department without a private physician are assigned one from the on-call rotation list. Upon discharge, patients from the northern states leave the area without follow up care; therefore, the attending of record could not provide us with information.

Research of the medical records of these sixty-four (64) expirations further revealed that:

- 30% (19 patients) had a poor prognosis for recovery
  - three (3) went home with Hospice Care
  - nine (9) were discharged home with Visiting Nurses Association and/or at home equipment (oxygen, home dialysis, IV's, etc.)
- 34% (22 patients) were discharged to an Extended Care Facility
  - four (4) patients had a DO NOT RESUSCITATE order while in the hospital



TELEPHONE (904) 263-4431
DOUGLAS J. HAMMOND
ADMINISTRATOR

CAMPBELLTON-GRACEVILLE HOSPITAL

"LARGE ENOUGH TO SERVE, SMALL ENOUGH TO CARE"
1305 COLLEGE DRIVE
GRACEVILLE, FLORIDA - 32440

TO: Health Care Financing Administration

FROM: Douglas J. Hammond, Administrator

SUBJECT: Mortality Rates

DATE: October 27, 1987

All of the rates for the Campbellton-Graceville Hospital are within the normal limits - except one, which is below the published rate. One factor in which we take exception is; all data reflects patients who die within 30 days after hospital admission, whether or not the patient is in our hospital at the time of death. There are many factors which contribute to the cause of death which were not taken into account by HCFA - some are - stage of illness, degree of family support, psychological condition and the amount of health care afforded earlier. And above all, this data only shows why the patient was admitted, not the actual cause of death. Quality care cannot be determined with data that is gathered in such a loosely formulated manner.

D. J. Hammond

Douglas J. Hammond

DJH/jw



CAPE CANAVERAL HOSPITAL

October 28, 1987

William Roper, M.D.
Administrator
Health Care Financing Administrator
Washington, D.C. 20201

Dear Dr. Roper:

The data used by HCFA indicate that a total of 69 Medicare patients admitted to Cape Canaveral Hospital died within 30 days of admission. Of these, 53 died while still a patient of the hospital, while 16 died after discharge. Our own records indicate that 1,768 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Cape Canaveral Hospital is correct. Our own records also indicate that of the 69 Medicare patients who died within 30 days of admission while still an inpatient, 16 were still alive at the time of discharge. It is impossible to determine the percentage of the 16 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

In none of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. In fact, in almost all categories, Cape Canaveral Hospital's rate falls very near the low end of the range.

Sincerely,

Larry F. Garrison
President

jt

Post Office Box 69 701 West Cocoa Beach Causeway Cocoa Beach, Florida 32931 305/799-7111

Cedars
MEDICAL CENTER

1400 N.W. 12th Avenue
Miami, Florida 33136
(305) 325-5511

October 27, 1987

William L. Roper, M.D.
Administrator, HCFA
Health Care Financing Administration
6325 Security Boulevard
Meadows East Building, Room D-2
Baltimore, Maryland 21207

Dear Dr. Roper:

Cedars Medical Center, a not-for-profit 680 bed tertiary care hospital, agrees with HCFA'S written statements regarding the limitations of the mortality data and the recommendation that the data not be used by itself to make judgments about the quality of care in an individual hospital.

As a JCAHO accredited hospital, the medical staff at Cedars Medical Center conducts monthly reviews of individual patient medical records for all diseases and operations to evaluate the quality of medical care and to improve the patient and family's satisfaction with the overall delivery of hospital services. This individual case review rather than just a statistical review is required to adequately address the many factors such as multiple diseases and the socioeconomic environment that effect the treatment and outcome of any one patient's hospital experience. Furthermore, we believe that quality of care reviews should be performed for all patients and not just patients whose outcome was death.

The review process conducted by Professional Review Organizations funded by HCFA to evaluate the necessity for hospitalization and the quality of care is also based upon individual patient medical record reviews. In addition, the attending physician may be contacted for additional information concerning the patient's social, family, and medical history in order to assess the severity of the patient's illness. This review process further supports the premise that individual medical record review is required to assess quality.

Analysis of HCFA Data

1. HCFA has requested that hospitals comment regarding errors in the data. There are 12 errors in the dates of hospitalization resulting in 4 errors in diagnostic category placement.

2. The category titled HL=Low Risk Heart Disease includes patients having open heart and other major heart surgery procedures; therefore, the term "low risk heart disease" is misleading.

3. Sixty-three (63) patients died outside the hospital; therefore, the cause of death is not known to the hospital. Placing these patients in the category related to the hospital admission is questionable.

4. A large percent of the "elderly" Medicare population resides in the Miami area. At Cedars Medical Center, 37% of the total deaths occurred in patients 85 years of age and older and 74% of the total deaths occurred in patients over the age of 74.

Cedars Medical Center supports nationwide efforts to develop indicators that truly measure the quality of care. As one example, the Joint Commission on Accreditation of Healthcare Organizations is expected to produce in 1990 a system to more precisely measure the quality of healthcare services.

HCFA is encouraged to support industry efforts to not only measure but to improve the quality and accessibility of healthcare services beyond the hospital setting. Services such as home health, nursing home, and hospice care provide a continuum of care that builds on the treatment provided in the hospital setting. The availability of these services directly affects the patient's health status.

Thank you for the opportunity to comment.

Sincerely,

Daniel L. Stickler
President and Chief Executive Officer

DLS:as

HOSPITAL # 100009 CEDARS MEDICAL CTR INC MIAMI FL

1986 data

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	2,687	11 %	9 TO 16 %
CA - CANCER	218	18 %	17 TO 33 %
CE - CEREBROVASCULAR ACCIDENTS	71	35 %	21 TO 44 %
EY - OPHTHALMOLOGIC DISEASE	15	0 %	0 TO 86 %
GC - GASTROINTESTINAL CATASTROPHES	69	19 %	8 TO 29 %
GI - GASTROINTESTINAL DISEASE	177	5 %	3 TO 11 %
GU - UROLOGIC DISEASE	127	11 %	2 TO 19 %
GY - GYNECOLOGIC DISEASE	17	0 %	0 TO 45 %
HL - LOW-RISK HEART DISEASE	356	4 %	3 TO 8 %
HM - SEVERE CHRONIC HEART DISEASE	117	23 %	17 TO 33 %
HS - SEVERE ACUTE HEART DISEASE	69	35 %	29 TO 55 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	45	18 %	11 TO 38 %
OP - ORTHOPEDIC DISORDERS	227	1 %	0 TO 5 %
PN - PULMONARY DISEASE	206	26 %	16 TO 30 %
RN - RENAL DISEASE	12	8 %	3 TO 53 %
SE - SEPSIS	49	47 %	27 TO 57 %
TR - SEVERE TRAUMA	77	10 %	5 TO 20 %

WN - All other diagnoses 49

FL 40.2

CA - WN = 307 total Deaths

2,687 = All medicare Admissions expiring within 30 days of last Admission Date.

CITRUS MEMORIAL HOSPITAL
502 Highland Boulevard • Inverness, Florida 32652-4754 • (904) 726-1551

November 2, 1987

Mr. William Roper
Department of Health and Human Services
Washington, D.C. 20201

Dear Mr. Roper:

We have received and reviewed the Department of Health and Human Services' mortality information relative to Medicare patients treated in our facility in 1986.

Since this is purely a statistical analysis we do not consider this information to be a measure of the quality of care provided by hospitals. We will, however, use this information as a source of data for our Quality Assurance Program.

Sincerely,

Charles A. Blasband
Chief Executive Officr

CAB/bjd

Coral Gables Hospital
3100 Douglas Road, Coral Gables, Florida 33134, 305/445-8461
"You'll Feel Like Family"

October 22, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration

Dear Dr. Roper:

Thank you for the opportunity to comment on the public release of hospital mortality data.

Statistically, Coral Gables Hospital data shows the mortality rates to be below or less than the predicted median in each category. Our hospital Medical Staff committees monitor every death in our facility on an ongoing basis. We believe our monitoring system provides us with a continuous feedback method to continue to meet and exceed quality care standards.

Coral Gables Hospital is a licensed 285-bed acute care facility whose case mix includes many patients with major medical/surgical problems. We are a general service facility and offer specialty services in diabetes, dialysis, orthopedics, urological services, and general medicine/surgery. The hospital has been accredited by the Joint Commission each time it has undergone inspection.

Sincerely,

Rafael R. Perez
Administrator

RRP/dg

cc: Jose Landa, M.D., Chief, Medical Staff

CORAL REEF HOSPITAL
9333 S.W. 152nd Street, Miami, Florida 33157, 305-251-2500

October 26, 1987

Mr. William Roper
Administrator
Department of Health and Human Services
Washington, DC 20201

RE: Mortality Review Data
Coral Reef Hospital
Provider #100208

Dear Mr. Roper:

After review of the Mortality Review Data, I feel that while the data may be essentially accurate, there are significant factors which are not being considered or reported. Because of these omissions, the information being reported is effectively meaningless to the public; however, it will be presented as an accurate barometer of the quality of care rendered by the hospitals.

The mortality figures reflect only the patient's principal diagnosis. While significant, a principal diagnosis is not generally the only cause of death. Many factors such as secondary diagnosis, the age of the patient, the patient's general health status, stage of illness, psychological condition and the amount of family support contribute to a patient's ability to overcome potentially life-threatening illness.

While these statistics do not paint a particularly bleak picture of Coral Reef Hospital, I believe to report the data as it now exists would be irresponsible on the part of HHS. I do not believe that even with significant qualifying statements the public could interpret this data in a meaningful manner and I request that you reconsider its release.

Thank you for the opportunity to comment on these statistics. Please contact me if I can be of any assistance to you.

Sincerely,

J. M. Fleetwood, Jr.
Administrator

JMF:ps

DELRAY COMMUNITY HOSPITAL

October 22, 1987

William L. Roper, M.D.
Administrator, Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Delray Community Hospital, Medicare provider #1700258 is opposed to the publication of Medicare mortality rates which include deaths within thirty days of admission to the hospital. The data, as presented, is misleading and wholly inconclusive for a number of reasons:

1. The data does not take into consideration the severity of illness of the patient. Many of the DRG's are very broadly defined in terms of scope and severity of the reported disease, age distribution of the patients treated, and existence of complicating or secondary diagnosis. For example, an otherwise healthy, 66-year-old [redacted] with heartbeat irregularities may be hospitalized for the insertion of a pacemaker. Another pacemaker patient, a 93-year-old [redacted] also suffering from a massive heart attack and congestive heart failure, could be categorized under the same grouping released by HCFA. These factors are not accounted for in the DRG groupings or in the model used to predict the mortality rate.

2. The mortality rates are based on the principal diagnosis, which may or may not have been the actual cause of death. For example, an elderly patient may have been admitted for major joint procedure and later had a heart attack and died. The data would have listed major joint procedure (the principal diagnosis) as the cause of death. This would incorrectly skew the mortality rate for the hospital's major joint procedure DRG.

3. The absolute number of cases treated within a DRG could skew the mortality rate. For example, suppose a hospital treats a very small number of cases within a DRG, (e.g. 5 cases) and due to the severity of cases within that DRG, two people died. This yields a 40% mortality rate, which may be high compared to the overall national averages for many cases. Given the small number of cases treated, this mortality rate could be extremely misleading.

4. At best, the HCFA information provides crude estimates of the hospital's actual mortality rates. According to the data, Delray Community Hospital experienced an 11% total mortality rate or 310 deaths within thirty days of admission to the hospital. However, of those 310 deaths, 21% occurred after discharge from the hospital, and should not be included in the hospital's mortality rate, thereby resulting in an actual in-house mortality rate of 8.6%. In short, no research has been done to determine the actual cause of death and whether it was related to the hospitalization or completely unrelated to the reason for admission. A comparison of the statistics by diagnostic category is summarized below:

DIAGNOSTIC CATEGORY	ACTUAL MORTALITY RATE OF IN-HOUSE DEATHS ONLY	HCFA MORTALITY RATE OF ALL DEATHS WITHIN THIRTY DAYS OF ADMISSION
CA-Cancer	16.1%	21.2%
CE-Cerebrovascular accidents	21.1%	24.4%
EX-Ophthalmologic disease	0%	0%
GC-Gastrointestinal catastrophe	14.0%	14.0%
GI-Gastrointestinal disease	1.2%	1.6%
GU-Urologic disease	1.7%	2.3%
GY-Gynecologic disease	0%	0%
GL-Low risk heart disease	1.6%	2.7%
HM-Severe chronic heart disease	23.9%	29.4%
HS-Severe acute heart disease	31.6%	33.3%
ME-Metabolic/Electrolyte	9.4%	28.1%
OP-Orthopedic	2.0%	2.0%
PN-Pulmonary disease	7.0%	9.3%
RN-Renal disease	11.1%	33.3%
SE-Sepsis	42.8%	42.8%
TR-Severe Trauma	10.5%	14.0%
UN-Unclassified	4.5%	6.6%
TOTAL	8.6%	10.9%

Furthermore, on several occasions, the HCFA data was incorrect in listing patients whose death occurred one to three days prior to discharge from the hospital. Upon investigation, these patients actually died on the day of discharge. This emphasizes the premise that the HCFA data should not be released before the data was validated.

As you are aware, all hospital are subject to a stringent series of checks and balances aimed at ensuring the delivery of quality health care. First, hospitals conduct ongoing internal assessments aimed at monitoring quality within their own facilities. All deaths occurring within the hospital are reviewed by a designated committee of physicians. Second, hospitals are subject to state and county health care licensing criterion which includes standards that must be adhered to by all hospitals. Without qualifying for state and municipal certification, hospitals cannot operate. Third, the Joint Commission on Accreditation of Hospitals, a private not for profit organization of health care professions, stringently reviews the quality assurance activities of hospitals and their medical staffs prior to awarding its coveted endorsement. JCAH evaluates hospitals every three years to ensure that objective criterion are used to measure quality patient care, in addition to reviewing actual patient cases in an effort to make certain that quality care is being provided.

Finally the Professional Review Organization (PRO), a federally contracted "watch dog", are mandated by law to monitor hospital utilization for all Medicare beneficiaries ensuring that the care delivered is necessary and appropriate.

Although HCFA views this disclosure of patient outcome data as part of an extensive quality review initiative, there must be an open acknowledgement of the limitations of the data and the need for continued refinement of the statistical model. Quality judgments can only be made after thoroughly reviewing a patient's medical record and not grouping random data together and releasing inappropriate statistics to the general public. This data cannot be used directly as a measure of hospital performance, but merely identifies potential areas for further evaluation.

Sincerely,

J. Michael Mastej
Executive Director

JMM/aec



October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
P.O. Box 26684
Baltimore MD 21207

Gentlemen:

We are concerned about your planned release to the public of selected mortality data as outlined in Dr. Roper's letter to us of September 21, 1987. While the data for our hospital indicated that our experience was within the "range of predicted mortality rates" for each diagnostic category, and additionally reflected favorably on our overall mortality rate with our death from "all causes" appearing at the low end of the spectrum, we disagree with this data being disseminated to the public. Our concerns are summarized below:

1. The concept that this basically raw mortality data can be of use to the general public defies reason; hospitals mortality rates will vary for many valid, justifiable reasons that have nothing to do with quality of care. Putting this data into the hands of the public suggests that they will then be better informed to make decisions as to which hospitals to utilize; however, even the Health Care Financing Administration (HCFA), with all the resources at their disposal, has been unable to articulate any conclusions from this data, and warns the public against doing so, too.

2. While Dr. Roper's letter indicates that "...it is possible that there are errors in the data used to conduct the analysis," and that "We (HCFA) would be particularly interested in any instances where our records are inaccurate regarding patient admission to your facility," we have determined that it is impossible to verify the mortality data given HCFA's formula for calculating mortality rates (i.e., the number of 1986 Medicare deaths in a given facility or within 30 days of admission is divided by only the number of 1986 Medicare admissions where the patient's last admission in 1986 occurred in this facility. Even if a facility is able to verify the numerator of this calculation (which is no small feat considering that a patient may die up to 30 days after admission and still be included), there is no way for a facility to verify the denominator of the calculation (i.e., we cannot determine if our last 1986 admission for a given patient was the patient's last admission for 1986, as the patient may subsequently have been seen elsewhere). Therefore, HCFA is disseminating information to the public that, at best, can only be partially verified by the hospitals it purports to portray.

3. In addition to the impossibility of verifying this data due to the

POST OFFICE BOX 2180 – 900 NORTH ROBERT AVENUE – ARCADIA, FLORIDA 33821-2180 – (813) 494-3535

formula HCFA has chosen to measure "mortality," we also take issue with the conceptual results obtained. That is, by including in the denominator only the last 1986 admission of Medicare's beneficiaries, the "mortality rate" obtained is vastly overstated due to the understatement of the denominator. Restated, many patients (especially Medicare beneficiaries) have multiple admissions during the span of a year; to exclude all of the earlier admissions where death did not result is misleading and may cause undue anxiety to Medicare beneficiaries and the public in general due to overstated "risk of death."

4. The Florida Hospital Association has distributed a document (copy attached) listing some 22 reasons why Medicare's DRG death data is misleading, all of which we are in agreement with, and some of the following of which we believe to be particularly relevant:

a) Since "The data include patients who die within 30 days after hospital admission, whether or not the patient is in the hospital at the time of death," it follows that "A death may result from poor care outside the hospital."

b) "HCFA admits the methodology used to develop the data is a 'crude tool.' HCFA openly acknowledges the limitations of the data and the need for continued refinement.

c) "In addition to the severity of illness, other factors contributing to the probability of death, also not taken into account by HCFA, are the patient's general health status, stage of illness, psychological condition and degree of family support."

d) "The age of the patient is another factor. Many deaths in Medicare DRGs are of individuals in their 80's and 90's who are often less likely to survive illness and injury." For example, in our hospital, in the first diagnostic category of "cancer," the average age of those patients who died was 73.2 years old, and should surely have some bearing on the patient's expected mortality; yet this information is apparently not to be distributed to the public.

e) "Patients and families of those admitted to the hospital in the final stages of illness often ask that no action be taken to prolong life." In fact, "Death is the expected result of many admissions."

f) "A hospital's mortality rate may be affected if the hospital is located in an area with a shortage of nursing home beds, where patients with chronic degenerative conditions may be admitted to the hospital shortly before death."

In summary, DeSoto Memorial Hospital is committed to the provision of quality patient care and welcome the efforts of HCFA in helping to

identify and resolve any abnormal patient care patterns that may be indicated in HCFA's review of the hospital industry's raw mortality statistics; however, we fail to see any good purpose being served by the release of this data to the public while serious potential exists to malign the reputation of even the best hospitals and mislead patients in the process.

Sincerely,

Jeffrey W. Smith, FHFMA, CPA
Vice President - Fiscal Services

P.S. Our Medicare provider # as requested in Dr. Roper's letter is 10-0175.

cc: Thomas J. Stone, President

DEATH RATE DATA DON'T MEAN A THING

. . . Why HCFA DRG Hospital Mortality Figures Do Not Measure The Quality Of Care

Florida Hospital Association
307 Park Lake Circle
P. O. Box 531107
Orlando, FL 32853-1107

(305) 841-6230

DEATH RATE DATA DON'T MEAN A THING . . .

The title of this guide is just as misleading as typical newspaper headlines on the subject. Death rate data do mean something to individual hospitals and the Florida PRO. "Death in the Hospital" was the headline of the first DRG death rate story in the nation, July 7, 1985 in the St. Petersburg Times. Although explanations of the data were buried in the story, the headline and comparison charts, labeled "HOSPITAL DEATH RATES", were misleading.

In the 1985 guide, "News Media Interpretation of PRO Medicare 'Death Rate' Data", published by the FHA, regional associations and Florida's PRO, support for the disclosure of accurate comparison data for consumers was stated along with warnings about potential misinterpretation of hospital mortality information. The FHA continues to advocate the distribution of accurate comparison information to help consumers make intelligent decisions when selecting health care providers.

Following the publication of DRG death rate comparisons in 1986 by the Health Care Financing Administration (HCFA), the government admitted the data were flawed. The data were designed for PROs, not the public. For example, the Nevada hospital shown with the highest death rate was a hospice.

Henry R. Desmarais, then acting director of HCFA, told the news media the statistics were not conclusive and had nothing to do with the quality of care. HCFA said they compiled the list to help PROs identify possible problems with hospitals. "It is not a report card on the nation's hospitals," said Dr. Desmarais.

As noted in the FHA's June 8, 1987 memo on HCFA's plans to release the data this December, HCFA developed a new approach because the 1986 release resulted in so much confusion. HCFA sought the advice of hospital, medical and consumer groups earlier this year. Although HCFA made some improvements in the process, and the data may be somewhat useful to hospitals and PROs, it is still ripe for misinterpretation by the news media and the public.

"The only way to determine whether or not a death in the hospital could have been avoided is to examine each patient's medical chart to discover the individual circumstances. Mortality rates do not say why a patient died," says the 1985 guide from the FHA, Florida PRO and regional associations.

While HCFA's planned release of the mortality information in December is a challenge for hospitals, it is also an opportunity to inform internal and external publics about the various provisions for quality assurance at the hospital.

WHY THE MEDICARE DRG DEATH DATA ARE MISLEADING

1. The data do not take into account the severity of the individual patient's injury or illness. Patients in critical condition from accidents and patients who are terminally ill are included in the data. When admitted to the hospital, the patient may be barely alive. Death is the expected result of many admissions.

2. Patients may have more than one medical problem. Some patients do not die from the principal diagnosis. For example, patients admitted under the pneumonia DRG have died from cancer, heart attacks and strokes, but the data show them in the pneumonia DRG. Mortality data only show why the patient was admitted, not why the patient died.

3. Multiple surgical complications of accident victims affect the result of surgery. It is obviously more difficult for surgeons to succeed with high-risk cases than with low-risk cases.

4. HCFA originally developed the DRG data to monitor Medicare billing, not the quality of care. The government is using a statistical tool (regression analysis) to do a job it was never intended for.

5. The data include patients who die within 30 days after hospital admission, whether or not the patient is in the hospital at the time of death. In the 30 days hospitals have to review and comment on the data, it is difficult to verify the circumstances of out-of-hospital deaths. A death may result from poor care outside the hospital.

6. HCFA admits the methodology used to develop the data is a "crude tool." HCFA openly acknowledges the limitations of the data and the need for continued refinement.

7. Some technical decisions HCFA made to generate the data tend to overstate the confidence the public will have in the predicted mortality rates. The statistical method assumes that the predicted rates are normal when they may not be normal.

8. HCFA's statement that differences between actual and expected mortality rates do not necessarily reflect especially high or low quality care is too deep within the notice, thus losing impact. The fact that statistical analysis is not capable of definitively attributing a death to care provided by a hospital will be missed by many readers.

9. HCFA has not conducted a validation study to determine if their statistical approach comparing mortality rates really reveals anything about hospital performance.

10. In addition to the severity of illness, other factors contributing to the probability of death, also not taken into account by HCFA, are the patient's general health status, stage of illness, psychological condition and degree of family support.

11. The age of the patient is another factor. Many deaths in Medicare DRGs are of individuals in their 80s and 90s who are often less likely to survive serious illness and injury.

12. The data do not show where the patients came from. Patients admitted through the emergency department are generally more high-risk candidates for surgery or treatment than others, and patients admitted from nursing homes tend to be sicker than those admitted who are still able to care for themselves at home.

13. Certain hospitals generally treat more seriously ill patients than other hospitals. Teaching hospitals and special units of some hospitals receive high-risk cases from other hospitals because they have the necessary high tech equipment and experienced physicians to provide extraordinary care. Logically, such hospitals would have a higher death rate for some DRGs.

14. The data may be misleading if there are only a small number of patients in a particular DRG. For example, if there are only two patients in a DRG and one dies, the death rate would be 50 percent. The smaller the number of patients in the DRG, the more likely the number is subject to misinterpretation. A particular death rate may be the result of chance, rather than medical care.

15. While DRG death rate percentages are available for individual hospitals, the figures do not reflect those physicians who practice at more than one hospital.

16. Although the information published applies only to Medicare, it can create a false impression of the overall quality of care at a hospital.

17. Patients and families of those admitted to the hospital in the final stages of illness often ask that no action be taken to prolong life.

18. Risk of death can be affected by a patient's genetic background or the lack of money to afford earlier health care.

19. A hospital's reputation may attract a high number of severely ill or injured patients. Hospitals with hospice service, heart and cancer centers can expect higher death rates.

20. The lack of confidence in the particular statistical model's predictions raises the question as to whether different ways of describing the clinical condition of patients result in different predictions of mortality.

21. A hospital's mortality rate may be affected if the hospital is located in an area with a shortage of nursing home beds, where patients with chronic degenerative conditions may be admitted to the hospital shortly before death.

22. While the HCFA data are not an accurate measurement of the quality of care at hospitals, the Joint Commission on Accreditation of Healthcare Organizations is working on a model quality of care indicator. A four-year process of study and extensive testing of the model is expected to produce an accurate measurement of quality care in hospitals by 1990.

HCFA's RELEASE OF DRG DEATH RATE DATA MAY BE MISLEADING. . .

. . . According to the following authorities:

"In most instances, it (death) is determined primarily by biological factors, but also partially by course of medical treatment."

William L. Roper, M.D.
Administrator,
Health Care Financial Administration
(August 30, 1987 Atlanta Constitution article)

"Serious technical problems must be solved before we will be able to infer the quality of care from death rates or other outcome measures."

Stephen F. Jencks, M.D.
Senior Research Physician
Heath Care Financing Administration
(September 10, 1987 article,
"Refining Case Mix Adjustment" in the
New England Journal of Medicine)

"Hospital mortality figures are already in the public domain . . . These figures do not represent measures of quality, but they will be widely construed as such. And hospital reputations and patient volumes will rise and fall on the basis of this numerical morass."

Dennis S. O'Leary, M.D.
President
Joint Commission on Accreditation of Healthcare Organizations
(July/August 1987 issue of the JCAHO's Perspective.)

"Floridians cannot judge hospitals based on individual hospital Medicare death rate data from the Health Care Financing Administration (HCFA). HCFA admits the data are limited and are designed primarily to pinpoint potential problems, not rate hospital care. The national accreditation organization for hospitals, the Joint Commission on Accreditation of Healthcare Organizations, is developing a measurement of quality care through extensive study and testing. The only real measurement of quality of care isn't expected to be published until 1990."

John M. McBryde
President
Florida Hospital Association
October 7, 1987

"I think the mortality data are interesting, however, I sure would not use it personally to make quality judgments about hospitals for myself, my family or my friends."

Kenneth G. McGee
Vice President/Health Economist
Florida Hospital Association
October 7, 1987

"It is important to note that these figures are not to be construed as quality indicators. They were not designed to measure the quality of care. No amount of warnings about potential misuse of the data can prevent some people from erroneously judging hospitals according to death rates."

Michael T. Rust
Director/Fiscal Services
Florida Hospital Association
October 7, 1987

"It has never been established that the statistical analysis provides a valid indicator to hospital quality."

"Some of the technical decisions made to generate the information will tend to overstate the confidence the public should have in the predicted mortality rates. Specifically, implicit in your statistical methods is the assumption that the predicted rates should be taken as normative. Consequently, users of the data may conclude that quality problems exist where, in fact, they do not, or vice-versa."

Jack W. Owens
Executive Vice-President
American Hospital Association
(September 14, 1987 letter to HCFA Administrator, William L. Roper, M.D.)

"They have made some changes in the statistical methods used to produce the data that will result in a more realistic picture of the limited confidence that hospitals or the public should place on HCFA's predicted hospital mortality rates. Further, HCFA is more openingly acknowledging the limitations of the proposed data and the need for continued refinement. Nevertheless, effectively responding to the release of these data will be a major challenge for hospitals."

Carol M. McCarthy, Ph.D., J.D.
President
American Hospital Association
(September 1987 cover memo with
"Understanding Mortality Rates")

"Statistical analysis of mortality rates can do no more than screen for further review. The data to be released by HCFA raise important questions, but they can not answer them. Quality judgments can only be made after reviewing the information contained in a patient's medical record."

"Understanding Mortality Rates"
Division of Hospital Finance
and Health Policy & Division
of Quality Control
American Hospital Association
September 1987

"We are pleased to see that HCFA appears to have abandoned a ranking system for hospitals, based on mortality statistics, but we still maintain that the methodology is invalid and inappropriate. It will not provide the public or hospitals with useful information for judging hospital performance."

James H. Sammons. M.D.
Executive Vice President
American Medical Association
(August 28, 1987 issue of
American Medical News)

"If you don't take severity of illness into account, the figures are meaningless. No information at this point is better than bad information."

James Todd, M.D.
Senior Deputy Executive
Vice President
American Medical Association
(September 28, 1987 issue of
HealthWeek.)

"I personally don't have a problem with releasing it, but I do have a problem if the government or the media tries to tell the public that this is more meaningful than it is."

Michael D. Bromberg
Executive Director
Federation of American Health Systems
(August 28, 1987 issue of American
Medical News)

"The data should not be used to shop for a hospital. Comparisons could be misleading without knowing patients' ages and other medical information, which is strictly confidential."

Tom W. Williams
Executive Director
Georgia Medical Care Foundation
(August 30, 1987 article in Atlanta Constitution. The latest publication of data by the news media.)

"DRGs do not adequately measure the range of severity of illness or intensity of care differences among patients within many diagnostic categories; do not recognize more than one complication or comorbid condition; and make little distinction for patient age."

Katherine R. Jones, Ph.D
Associate Professor
Graduate Program in Health
and Hospital Administration
University of Florida
("Severity of Illness
Measurement Systems,"
October 1987, Florida Health
Policy Brief.)

RECOMMENDATIONS

The Florida Hospital Association continues to urge all hospitals to be familiar with their own mortality rates as part of their ongoing quality assurance program. Hospitals should not wait until the data are released to the news media, the public or to competitors, before analyzing the data, preparing to explain it to external publics and informing internal publics.

Internal publics, especially those in close contact with patients, should be informed about hospital quality assurance procedures and the limitations of the data. Many patients will ask medical staff members, nurses and others about the data.

Explanations of individual hospital death rates should be specific. Blanket statements questioning the validity of the data are no substitute for specific explanations as to why particular death rate percentages are different from other hospitals or state or national averages. Specific examples should be helpful.

Hospitals may answer news media inquiries with general statements on the potential for misleading consumers, but such statements should be consistent with their own specific explanations of death rates at their institutions.

"Understanding Mortality Rates," provided to hospitals in September 1987 by the American Hospital Association, shows:

(a) How to understand the adequacy and limitations of the HCFA data;
(b) How to effectively use the opportunity for comment on the data prior to publication; and
(c) How to respond to press and public inquiries when the data are published.

The American Hospital Association and other groups were able to convince HCFA to allow hospitals to receive the data in advance for verification of accuracy and to develop explanations that will be released with the data. The 30-day comment period is barely enough time for most hospitals to check the data and develop comments.

Verification of the data, specific explanations for comments to be attached to the data, preparation to handle inquiries from the news media and public requires a "team approach" within the hospital. Since it may take considerable skill to convert complex explanations into simple, easy-to-understand statements, public relations staff should be involved.

Statements of caution in interpreting the data at the beginning of articles and broadcast stories should be suggested to the news media, as they develop mortality rate stories. Since most people read only headlines, charts and lead paragraphs, warnings about potential misuse of the data would not be seen if they appear deep in the article.

Hospitals that have "low death rates" may be tempted to use them in marketing efforts. However, the rates may go up next year resulting in news coverage that may make the hospitals look as though they are suffering a decline in quality care.

Questions from the news media about statewide significance of the data may be referred to the Florida Hospital Association.

THE FUTURE

Individual hospital death rates are available from HCFA and Florida's PRO, the Professional Foundation for Health Care, Inc., to anyone at any time.

HCFA has already announced they plan to publish death rate data each year, even though they admit the process is a "crude tool" that needs continued refinement. Next year's release will compare hospitals' performance in 1986 and 1987 on a variety of procedures.

HCFA Administrator William Roper, M.D., has referred to the mortality data releases as one of the "high points" in his service to the nation. He wants to move beyond i npatient care to HMOs and outpatient services.

Until the expected publication of a tested quality of care measurement system by the Joint Commission on Accreditation of Healthcare Organizations in 1990, the annual release of death rate data will focus attention on an inaccurate method of rating hospitals.

October 7, 1987
Florida Hospital Association

DOCTORS' HOSPITAL
5000 UNIVERSITY DRIVE • CORAL GABLES, FLORIDA 33114-1739 • (305) 666-2111

October 21, 1987

Health Care Financing Administration,
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Doctors' Hospital - Coral Gables
Medicare Provider # 10-0020

Following are our comments for release with your mortality data for our hospital.

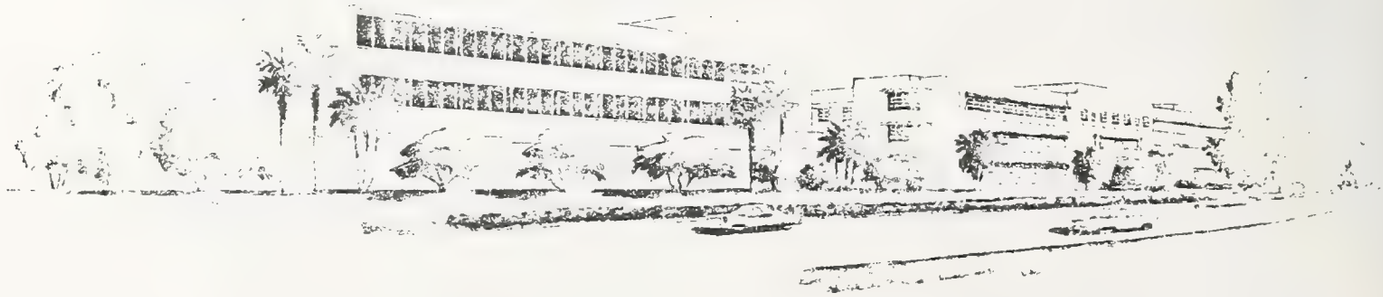
The recent mortality figures for Doctors' Hospital released by HCFA are, at best, flawed. Careful inspection and conclusions showed they have very little relationship to reality.

Nowhere in their statistics is there ever considered severity of illness. If you have elderly sick patients and are treating their severe illnesses, the mortality rate will be higher than in a place treating minor illnesses. But this is never addressed in HCFA's figures. The figures they have released for Doctors' Hospital are well within their "Range of Predicted Mortality Rates;" however, their figures have no meaning.

HCFA's information has been gathered in a manner not recognized by hospital standards and HCFA acknowledges that the information they are publishing is "not a complete measure of quality."[1] It does not begin to be complete.

---

1 Letter from Department of Health and Human Services, HCFA, William L. Roper, Administrator, September 21, 1987.



The information which HCFA used came from a billing form which, other than identification data and charges, has 10 spaces for entries of codes which represent your diseases and operations.

For facts and figures consider the following: HCFA tells us we had 180 Medicare deaths for the year, 1986. We have verified that 142 occurred in this hospital. There is no way of verifying the 38 that HCFA tells us died after leaving the hospital. HCFA recommended that we not contact the family to verify this. HCFA's letter states: "We hope that you will not find it necessary to contact family members of these patients that did not die in your hospital."

HCFA credits the hospital with any death that occurred 30 days after the day of admission. How HCFA chose this time period is not known. What about the patient who dies 31 days later?

Because of cost and time, we decided not to research each case; that our time would be better spent in areas directly benefiting patients. We even considered not responding at all to such unreliable information. After all, we are well within their "Range of Predicted Mortalities."

Using mostly the information submitted to us by HCFA and a log, we did verify that there were 18 differences in ages of patients: Example, HCFA states a patient was 97; we have the patient as 101. HCFA states we had 1,886 patients with an overall mortality rate of 10%. We had in excess of 3,000 Medicare admissions for a mortality rate of 5.5%. (HCFA does not count previous admissions.) Causes of death ranged from accidents to heart attacks.

Ages of the patients ranged from 57 to 97 or 101 depending upon whose figures are used. The age most common for the patients who died was 83. The average age was 81.

We do not know the cost of this huge project by HCFA nor do we know the costs of other HCFA activities, but we have heard that the professional review organizations' activities throughout the 50 states cost $300,000,000. We do know that some of you are feeling the tightening of funds allotted to the Medicare program. We do know that the medical profession and the hospitals objected to the Medicare program prior to its inception. Yet, today many of you think that the doctors and hospitals wanted it.

Please communicate with either William H. Comte, Executive Director, or me if you have any questions.

Thank you

Ruby H. Kennedy, R.R.A./mw

Ruby H. Kennedy, R.R.A., Director
Quality Assessment/Utilization

Doctors Memorial Hospital

A National Healthcare, Inc. Facility

P. O. Box 188
401 E. Byrd Ave.
Bonifay, FL 32425
904/547-4271



MEMO

Date: October 22, 1987

To: William L. Roper, M.D.
Administrator
Department of HRS

From: Robert E. Winkler,
Administrator

Re: HCFA Mortality Data

Medicare Provider #: 100078

The Mortality Statistics provided us by your department were verified with our records and were found to be accurate.

Reference the above statistics, I would like to comment regarding our hospital's actual mortality rate in only one diagnostic category, namely, cancer. Factors that contribute, I believe, to a 71% actual mortality rate for our hospital are as follows:

1. Our hospital's service area population consist of one of the lowest socio-economic levels in the state.

2. Due to our population's low socio-economic level, there is limited knowledge of health problems and usually insufficient income to pursue intense preventive health care check-ups.

3. Patients tend to present to our hospital at a late stage of disease process, thereby inhibiting a positive prognosis.

4. A shortage of nursing home beds in our hospital service area.

5. Limited home health care service availability in our hospital's service area.

6. Desire of family "to take care of their own family members" until near death.

Although the above factors tend to substantiate and explain the actual cancer mortality rate for our hospital, I would admonish the public to use additional factors when evaluating a hospital's efficiency and effectiveness in providing quality health care.

REW/js

Doctors' Memorial Hospital

407 E. Ash Street / P. O. Box 1090 / Perry, Florida 32347
Telephone (904) 584-6131

October 23, 1987

WILLIAM H. ANDERSON
Administrator

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Medicare Provider #: 100106

Dear Sirs:

Doctors' Memorial Hospital's excellent results in the HCFA study are an indication of the concern and care rendered by the medical staff and employees of the hospital. The results of the study show the strong commitment of the Board of Trustees, the members of the medical staff and each employee to delivering quality health care to every patient.

The interpretation of the HCFA data should be tempered by several factors:

A. The data does not take into account the severity of the patient's injury or illness. Patients in critical condition from accidents and patients who are terminally ill are included in the data. When admitted to the hospital, the patient may be barely alive. Death may be the expected result of the admission of these patients.

B. Patients may be admitted with more than one medical problem. Some patients do not die as a result of the principal admitting diagnosis. For example, patients admitted under the pneumonia DRG have died from cancer, heart attacks and stokes but the data show them in the pneumonia DRG. The HCFA study data only shows why the patient was admitted not why the patient died.

C. The data includes patients who die within 30 days after hospital admission, whether or not the patient is in the hospital at the time of death. It is difficult to verify the circumstances of out-of-hospital deaths. A death may have resulted from poor care received outside the hospital or circumstances unrelated to the hospital admission.

D. HCFA admits the methodology used to develop the data is a "crude tool". HCFA openly acknowledges the limitations of the data and the need for continued refinement.

E. HCFA has not conducted a verification study to determine if their statistical approach comparing mortality rates really reveals anything about hospital performance.

While the HCFA data are not an accurate measurement of the quality of care at Doctors' Memorial Hospital, the Joint Commission on Accreditation of Healthcare Organizations is working on a model quality of care indicator. A four year process of study and extensive testing of the model is expected to produce an accurate measurement of quality care in hospitals by 1990. Doctors' Memorial Hospital has been accredited by the JCAHO for over 25 years.

Sincerely,

William H. Anderson
Administration

WHA/kn

HCA East Pointe Hospital

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Sir or Madam:

Thank you for your correspondence dated September 21, 1987 regarding the publication of selected mortality information about all short term acute care hospitals which treated Medicare patients in 1986. As requested, we have reviewed the information upon which your calculations are based to assist you in verifying the accuracy of the information you have about our hospital and the following comments are made as a result of that review:

The data used by HCFA indicate that a total of 105 Medicare patients admitted to East Pointe Hospital died within 30 days of admission. Of these, 90 died while still a patient in the hospital, while 15 died after discharge. Two of the patients who died after discharge, died at another hospital, and at least four other patients died from causes unrelated to their reason for admission to East Pointe Hospital.

Our own records indicate that 1528 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. However, verification of our records indicates 1132 Medicare patients were treated at East Pointe Hospital in 1986. The difference between the number of Medicare admissions and patients treated is accounted for by patients being readmitted later in the year.

Areas of discrepancies between HCFA data and our own data that alter the actual mortality rates, are as follows:

DIAGNOSTIC CATETORY	CASES		MORTALITY RATE		RANGE OF PREDICTED MORTALITY RATE
	HCFA	ACTUAL	HCFA	ACTUAL	
All causes	955	1132	11%	9%	9 to 16%
CA-Cancer	90	101	20%	18%	14 to 34%
HL-Low risk heart disease	96	124	7%	6%	1 to 11%
HM-Severe chronic heart	55	70	31%	24%	14 to 37%
HS-Severe acute heart	33	50	42%	28%	24 to 57%
PN-Pulmonary disease	84	103	19%	16%	12 to 31%
RN-Renal disease	4	6	50%	33%	1 to 76%
SE-Sepsis	9	11	22%	18%	8 to 64%
TR-Severe Trauma	17	21	6%	5%	2 to 35%

1500 Lee Boulevard
Lehigh Acres, Florida 33936
Telephone (813) 369-2101
A subsidiary of HCA The Healthcare Company

The Department of Health and Human Services, National Center for Health Statistics recently released statistics showing that in 1986 the average life expectancy in the United States had risen to 74.9 years. Sixty-five percent (65%) of the 105 patients included in the HCFA mortality data for East Pointe Hospital were 75 years old or older. The average age at death for these patients was 79.3 years. Seventy-three percent (73%) of the patients who died were admitted under emergent circumstances. Given the patient's medical condition, or as a result of following the patient's wishes with respect to use of extraordinary efforts, death was the anticipated outcome at the time of admission, for 69% of the patients who expired.

It is impossible to determine the percentage of the 15 patients dying after discharge, who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Sincerely,

Les Beard

Les Beard
Administrator

:pcc

cc: Administrative Staff
N. Karns, ADON
S. Roach, Medical Records
P. Moss, Special Projects

Fawcett Memorial Hospital

Another
Basic
American
Medical
Company

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington D.C. 20201

Dear Dr. Roper:

All Fawcett Memorial Hospital's morbidity categories were within the predicted range, which is dependent upon age and sex of the patient, type of illness and complications. We would like to comment on the category of Renal Disease since it fell into the high area of the predicted range.

Of the thirteen cases that were admitted to Fawcett Memorial Hospital, eight patients expired (62%). Of these eight patients, six were transferred from other hospitals (Fawcett Memorial Hospital is the only community hospital that has a dialysis unit for renal disease patients). Families of seven patients requested that no heroic measures be taken as these patients were terminally ill with complications such as cancer.

The average age of these eight patients was 74. In review of these patient records, the likelihood of death was expected on admission due to the nature of the patient's disease, i.e. end-stage renal disease, and the complications present. These patients received quality care by the excellent physicians and nurses that we maintain on Fawcett's staff of professionals.

Very truly yours,

R. Wayne Cole
President

RWC/LT/kh

21298 Olean Boulevard
Port Charlotte, Florida 33952-6765
(813) 629-1181

FMH

FISH MEMORIAL HOSPITAL

245 EAST NEW YORK AVENUE
P.O. BOX 167
DELAND, FLORIDA 32721-0167
Telephone (904) 734-2323

MEMORANDUM

TO: Health Care Financing Administration

FROM: Thomas C. Dandridge, Administrator Hospital Provider Number 100072
Fish Memorial Hospital
DeLand, Florida

DATE: October 21, 1987

Subject: Mortality Data to be Published

While the actual mortality figures for this hospital fall within the ranges of expected mortality computed by the Health Care Financing Administration (HCFA), I have considerable doubt that these statistics have any general implications as a measure of the quality of care rendered to patients treated at this hospital. About the only conclusion that can be drawn from these figures is that there appears to be a statistical relationship between the five patient characteristics chosen by HCFA and the risk of death as defined by HCFA. However, HCFA has offered no evidence and there is no consensus among health care experts that these five patient characteristics represent the most significant factors which influence the risk of death.

The clinical literature has been saturated with the continuing debate over which factors characteristic of the health care provider actually have a direct, significant influence on the quality of care, not to mention the equally perplexing question of what actually constitutes reliable and valid measures of the quality of care. Consequently, to draw more than the narrowest of conclusions from HCFA's data mentioned above would require a large, unsubstantiated leap in logic. Unfortunately, I fear that some members of the public, news media, and even the health care field will wander outside the narrow conclusions to derive much more general, though invalid, inferences from this data.

This institution has a comprehensive quality of care review program which involves both concurrent and retrospective reviews of every facet of patient care. This complex process is geared toward identifying areas of patient care that can be improved.

Information for this extremely time-consuming process is generated from every hospital department which is involved in patient care. Mortality data is merely one aspect of patient care which is reviewed. Not only is there a thorough review of patient care information, but we also have developed a corrective action plan

which is an integral part of the whole quality review program. So not only are areas of improvement noted, but methods to effect improvement are continuously developed. The Governing Board mandates this comprehensive program in its Bylaws. Results of quality review activities are routinely reported to the Governing Board for its approval.

The data presented by HCFA has been reviewed by the hospital's quality review staff, but due to its limited validity as a measure of quality and because all patients in the HCFA study have already been scrutinized by the hospital's quality review program described above, the HCFA mortality data will constitute only a very minor part of the hospital's overall quality review function.

Florida Medical Center
5000 West Oakland Park Boulevard
Ft. Lauderdale, Florida 33313 (305) 735-6000

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health &
Human Services
Washington, D. C. 20201

IN RE: MEDICARE PROVIDER NO. 10-0210

Dear Dr. Roper:

Thank you for the opportunity to provide comments concerning the selected mortality information which the Health Care Financing Administration intends to publish in December, 1987.

My Staff and I have carefully analyzed the statistical data and the methodology used by HCFA to arrive at estimates of "expected mortality". We are of the opinion that HCFA is on the right track toward the development of realistic and meaningful methodologies to evaluate expected mortality, but would add these comments.

Although the data provided by HCFA to this Hospital indicated that our mortality is well within the "expected mortality" range and, for the most part, is on the low side, we are of the opinion that the introduction of additional, definitive and measurable patient characteristics are appropriate in order to obtain a more valid expectation of mortality. Specifically, the intensity of illness, the severity of illness and the diversity of illness (multi-system disease) must be measured not only independently but in combination form. A patient may have a number of systemic diseases, which, in combination, create a higher risk category than if independently measured. An insulin dependent diabetic, for example, with significant insulin dependence, in combination with a chronic, highly elevated hypertensive condition, further complicated by frank renal disease as measured by high abnormal creatine/BUN levels is a higher risk, sicker patient than a non-insulin dependent diabetic, with moderate hypertension and mild renal disease.

The addition of these characteristics into the methodology process of arriving at expected mortality would be more indicative of higher risk patients. **Indeed, the mortality statistics of this Hospital would be substantially lowered and would be even more favorable compared to those of surrounding community hospitals if the methodology process of arriving at expected mortality took into account a higher risk category created by the combination of high intensity illness, multi-system diseases.**

Thank you for the opportunity for this public comment.

Yours truly,

Edward A. Dauer M.D

EDWARD A. DAUER, M.D.
ADMINISTRATOR

EAD/pyl

FLORIDA HOSPITAL
601 EAST ROLLINS STREET
ORLANDO, FLORIDA 32803
(305) 896-6611

October 12, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Attention: HSQ-148-GNC
P. O. Box 26678
Baltimore, MD 21201

Re: Hospital Mortality Data

Dear Dr. Roper:

Even though our institution falls within the acceptable ranges of the mortality data, we object in the strongest terms to the release of this information to the general public. You state that HCFA will make clear that the information on its own is not a complete measure of the quality of care in an individual hospital. However, given the high profile and the emotionality of death rates, the public will use it as a complete measure of a quality of care. This will happen particularly in the absence of any other statistical measures.

The second point of our objection has to deal with the methodology employed to determine the ranges of the death rates. We do not know what assumptions went into the development of these measures, what weights were given to different factors and how certain decisions were reached to use certain statistical approaches versus others. Without a thorough understanding of the methodology and its inherent limitations, complete understanding and interpretation of the data is not possible by the public at large or by health care professionals.

I believe it would be much more responsible if Health and Human Services would start with less volatile and emotional data in its efforts to bring about a focus upon the issue of quality.

Sincerely,

Richard E. Morrison
Vice President

ec

FLORIDA HOSPITAL
601 EAST ROLLINS STREET
ORLANDO, FLORIDA 32803
(305) 896-6611

October 27, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Although the 1986 mortality data released by the Health Care Financing Administration's (HCFA) reflects well on Florida Hospital, our administration wishes to go on record as critical of the statistics. As Scott Miller, Senior Vice President of Florida Hospital, pointed out in his September 9, 1987 letter to you, we believe there are serious flaws in both the assumptions and methodology being used.

It is our belief that the release of mortality data could be misleading to the public who may interpret the information as a complete measure of quality of care. We are concerned that the general public may mistakenly believe that the lower the expected mortality range, the better the hospital (and vice versa). This may not always be the case. The reason is that the HCFA methodology does not use a reliable method of measuring the severity of patients treated at regional referral centers like Florida Hospital. Without this factor being accurately accounted for, the use of death rates may be highly misleading.

While this year's methodology attempts to get a severity of illness, it still does not go far enough. It does not measure levels of severity within each of the 16 diagnostic categories and this is a serious shortcoming. Dividing cases into six low and ten high risk categories does not adequately identify the really sick patients treated at tertiary referral hospitals like Florida Hospital.

The data also does not take into consideration several factors with a significant impact on mortality, such as the patient's general health status, genetic background, the stage of his illness and earlier health care, the urgency of surgery, his psychological condition and level of family support. Including patients who die within 30 days of admission, whether or not the patient is in the hospital at the time of his death, does not address the issue of follow up care.

Furthermore, the public may be led to believe that the data applies to all patients, not only Medicare patients, many of whom are higher risk because of advanced age.

The hospital's large number of patient transfers and other critically or terminally ill patients includes a high percentage of patients who are not expected to live. Many have more than one medical problem. Many are at high risk for surgical complications because of the seriousness or complexity of their medical problems. For example, the condition of many of our patients with chronic heart disease is complicated by congestive heart failure, renal failure and the like; terminal cancer patients come here for specialized treatment; and patients suffering from strokes , head injuries or other traumas often require our specialized neurological services.

A patient with chronic heart disease and complicating illnesses was helicoptered here in September of 1986 from a smaller hospital because we are equipped for advanced cardiac treatment. Within just minutes of arrival here, he went into cardiac arrest; because of the advanced and chronic nature of his disease, further treatment efforts could not save him. His death counted toward our statistics.

While HCFA's statistics show that we treat medicare patients within the normal mortality rates, we still believe the HCFA mortality data does not accurately reflect a severity of illness adjustment. We will continue to push for a better data-gathering model, and object to the release of data which may be very misleading and misconstrued.

My comments and those submitted by my staff are to be considered our official response to the release of hospital specific mortality data.

Sincerely,

Thomas L. Werner
President

db



Florida Keys Memorial Hospital

October 16, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C., 20201

Dear Doctor Roper:

This responds to your September 21, 1987 letter on December publishing of Medicare mortality information and the printout applicable to our hospital. Our Quality Assurance Comittee is conducting a detailed comparison to determine the accuracy of your materials.

We continue to feel that the mortality data has use to our quality assurance effort but is, as HCFA has described, a "crude tool". That it might be mistakenly used as a consumer guide to healthcare is appalling to us.

Our hospital happens to fall within the predicted range of rates which is fortuitous but we take no comfort from it. Within the fourteen listed diagnostic categories we have five where no deaths occurred. The total number of cases within those five were only 63. We also had two 100% mortality rates, in both instances there was only one case.

While we applaud your decision to provide opportunity for published response we have considerable difference with your claim that the data will help consumers make more informed decisions about their health care. Disclaimers such as you propose to keep consumers from making judgements about hospital quality are generally lost to sensational headlines and fine print. Frankly, we are unable to determine a reasonable purpose for publishing data you admit to be limited.

Sincerely,

GEORGE AVERY, FACHE
Executive Director

GADSDEN MEMORIAL HOSPITAL
U.S. 90 EAST • POST OFFICE BOX 819 • QUINCY, FLORIDA 32351 • (904) 875-1100

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Gadsden Memorial Hospital is truly committed to meeting the health care needs of Gadsden County and the surrounding areas. This is exemplified by the concern shown to all patients by our staff and our excellent record of quality patient care over the years.

I wish to take a few moments to address HCFA's release of mortality statistics for all hospitals and to comment on the specific statistics derived for Gadsden Memorial Hospital. First of all, let me express my agreement with the public need to have objective, valid, and unbiased information about death rates in hospitals, but only as long as all contributing factors are known and controlled for, and all factors can be positively correlated with contributing to patients' deaths. I do not believe HCFA's statistical methodology adequately addresses either of these concerns.

HCFA plans to list deaths for 16 medical conditions, with a 17th category as a catch-all for all others. Obviously, this last category contains different medical conditions for different hospitals, and thus are not comparable. Gadsden Memorial Hospital cannot verify the accuracy of data presented by HCFA on deaths after discharge, because this information is not accessible to hospitals, unless the decedents' families are contacted.

HCFA's data do not take into account the severity of the individual patient's illness or injury when the patient arrives and is admitted to the hospital. In addition, the patients in diverse socio-economic and demographic areas may have varying accesses to pre-illness and routine medical care, which will tend to skew the

results for individual hospitals. For example, because Gadsden County has a large poor population, many residents may not be able to receive appropriate and necessary follow-up care simply because they cannot afford to pay for it. The degree of psychological, social, and family support is also vitally important for good health and is affected by different socio-economic variables.

As a basis for the data used in its statistical compilations, HCFA used the patient's principal diagnosis for admission. This does not address multiple medical problems. A patient who is admitted for one diagnosis but is further debilitated by another problem may die, with the cause of death being attributed by HCFA to the principal diagnosis. Where in actuality, the two problems together may have caused the patient's demise. HCFA's methodology does not control for these types of situations. Looking at the mortality data HCFA prepared for Gadsden Memorial Hospital, there was one patient in 1986 who was treated for a gynecological disease. This patient died, thus giving Gadsden Memorial an "actual mortality rate" of 100%. In reality, this patient was admitted in May for a gynecologic procedure. But four weeks later, this same patient was again admitted, but this time for a stroke. This patient eventually expired because of the stroke, not the gynecologic disease. But looking at HCFA's mortality statistics, it appears that this patient died while being treated for a gynecologic disease, which was not the case.

Since Gadsden Memorial Hospital is a 51-bed hospital, it does not see the volume of patients in each category as would larger hospitals. Because of this small number, the actual mortality rate calculated on the number of patients who died per the number of actual cases may be more due to chance than anything else. The sample size may be relatively low and the results obtained may be statistically insignificant, and thus should not be used as a basis for comparing hospitals.

The statistical methodology was only coarsely explained in the Federal Register, so it is difficult to verify the accuracy of the figures stated by HCFA. HCFA's figures show 332 Medicare cases being treated at Gadsden Memorial Hospital during 1986. Our verified data show that, in actuality, we had 556 discharges.

The difference should be those patients who were admitted more than once during 1986, since HCFA is only including the last 1986 admit for each Medicare patient. Unfortunately, there is no way to verify this information without looking at every case.

In two categories that we did look at, however, we noted definite discrepancies in the statistics. According to HCFA's data, Gadsden Memorial had nine Medicare patients treated for cancer, of which six died. But our verified data show that, in fact, we had fifteen Medicare cancer cases during 1986, with six deaths. This decreases our mortality rate from 67% to 40%. The same was true for the "severe acute heart disease" category. HCFA's data show three cases treated in 1986 with two deaths, for a 67% mortality rate. Our verified data shows eight Medicare patients treated with two deaths, for a 25% mortality rate.

In conclusion, because of all the limitations of the statistics and the assumptions that are made in their use, the public should not use them to compare the quality of medical care provided at the hospitals. In addition, since there are major discrepancies between HCFA's statistics and the statistics of Gadsden Memorial Hospital confirmed by actual case data, HCFA's statistics about Gadsden Memorial Hospital are not valid or reliable.

Gadsden Memorial Hospital provides excellent health care to the patient population it serves, as substantiated by the Florida's Peer Review Organization's only reviewing the minimum number of our patients' charts. So I warn the public to be careful in evaluating the utility of these mortality statistics. Using HCFA's statistics as is, Gadsden Memorial Hospital is providing high quality patient care. If HCFA's statistics were accurate and the methodology assumptions strengthened, I am confident that Gadsden Memorial Hospital would surface as one of the premier hospitals around.

Sincerely,

Steven D. Patonai
Administrator

GOOD SAMARITAN HOSPITAL

KENNETH A. WEDA, F.A.C.H.A.
President

October 27, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for allowing us to review the Health Care Financing Administration's Medicare Mortality information on patients admitted to Good Samaritan Hospital prior to releasing this information to the news media. We have reviewed the information you provided us and have the following comments:

Good Samaritan Hospital's governing board, management, and medical and nursing staffs constantly strive to provide our community with quality care. Whenever a problem concerning quality of care is identified, it is investigated and corrective action is taken. Actions such as providing education, restriction or loss of privileges, continued monitoring and termination of employment have been used to address quality issues. Our hospital is committed to insure that quality care is provided.

Mortality rates of Medicare patients, by themselves, do not measure quality of care. An appropriate assessment of hospital performance is dependent upon many variables and requires a look at many quality indicators of which mortality is only one. Actual mortality rates can be higher or lower than predicted because patients treated by a hospital differ from patients treated in an "average" hospital. Comparisons of actual and predicted mortality rates can only suggest that the hospital and its medical staff review an area to determine if a quality problem exists.

Every medical record of a deceased patient is reviewed by a medical staff committee. Further, the Federally contracted Peer Review Organization (PRO) reviews medical records for quality and appropriateness of care.

While we believe that information on Medicare mortality rates is useful, it does not include measures of severity of illness, such as the patient's condition at the time of admission, whether the patient was transferred to the hospital from a

Flagler Drive at Palm Beach Lakes Blvd., Post Office Box 3166 • West Palm Beach, Florida 33402-3166 • (305) 650-6201

nursing home, whether the patient was receiving treatment at home prior to admission or whether the patient had a terminal illness. As a result, hospitals treating large amounts of trauma, severely ill patients in cancer treatment units and active intensive care units may have higher than predicted mortality rates.

Finally, this data includes Medicare patients who died within thirty days of their last admission, even though their death may be totally unrelated to the medical condition for which they were treated, including accidental deaths, or situations where the patient was discharged so as to be at home at the time of their death. Since this mortality rate reflects deaths that occurred outside of the hospital, we are unable to totally verify the information.

Good Samaritan Hospital has had a quality appraisal program for many years and will continue to conduct its own quality appraisal program.

Thank you for the opportunity to comment on this information.

Sincerely,

Kenneth A. Weda
President

KAW:jb



Ron R. Rees, F.A.C.H.E
Administrator

October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Comments of HCFA Mortality Data
Medicare Provider # 100017

Dear Dr. Roper:

Data Verification

The data presented by HCFA suggest favorable results for Halifax Medical Center in relation to expected mortality ranges. Information released to the public must contain clear language to describe the meaning of the mortality percentages. Because of the variance in severity of illnesses of patients involved, flat mortality percentages are misleading. The figures should only be used as they relate to the expected ranges. By strongly delivering this message with the data, the HCFA report will not only be more accurate, but more helpful.

In at least two of the categories, there was some question as to the accuracy of the number of cases. These were renal disease and severe acute heart disease.

Renal Disease

We verified the number of deaths and medically reviewed each case. They were all very seriously ill patients with multiple comorbidities, multiple hospital admissions and poor medical histories. Two of the cases were transferred to us from other area hospitals because of the seriousness of their conditions. One was maintained on a ventilator with multiple body system failures and the other had a ruptured aortic aneurism repaired, suffered renal failure, and was then transferred to us near death. We receive the most seriously ill renal patients because we have the only acute and chronic inpatient kidney dialysis service in the county.

Severe Acute Heart Disease

The total cases of severe acute heart disease seen numbered 162, much greater than the 124 reported by HCFA. Attachment 1 presents those cases for your review. Our mortality percentage will be better once the cases are reviewed and the calculations revised.

Further Interpretation

Halifax Medical Center's data are well within the expected rates as computed by HCFA in all diagnostic categories. Our overall hospital percentage was better than the average expected death rate. Although Halifax Medical Center's results were excellent, we do have concerns with the use of the data.

Halifax Medical Center provides many unique services within the area that no other area hospitals provide including acute and chronic renal dialysis services, hospice, Regional Oncology Center, radiation therapy, designated Level II Trauma Center, neurosurgery, neonatal ICU, and lithotripsy. In other services that are not unique, Halifax has the most advanced technology and comprehensive equipment. We are a regional referral center because of this wide range of offered services and advanced technology, so we accept the sickest patients either by direct admission from physicians who want the most complete care or from hospitals that cannot treat the most severe cases. This severity of illness factor would skew our mortality rates in comparison to other local hospitals when we admit patients near death. Publication of this data without the above clarification can become a strong negative incentive for major referral centers to accept these severe cases and transfers near death.

The Quality Assurance function of a hospital is critical for monitoring quality of care. As part of our Quality Assurance program, all mortalities are medically reviewed by physician committees. There are many other quality indicators which we monitor to give a complete picture of quality.

In conclusion, we strongly recommend that HCFA provide adequate instructions and explanations when the data are released. Failure to provide that information could harm not only the health care system, but also the patients using that data to make health care choices.

Sincerely,

Ron R. Rees
Administrator

Attachment 1

SEVERE ACUTE HEART DISEASE PATIENTS

HIC #	NAME	DISCHARGE DATE	ADMISSION DATE	PRINCIPLE DIAGNOSIS
[redacted]	[redacted]	02/19/86	02/10/86	41040
		12/26/86	12/19/86	41040
		01/31/86	01/25/86	41040
		10/03/86	09/26/86	41040
		04/06/86	04/04/86	41040
		01/23/86	01/16/86	41040
		07/17/86	07/03/86	41040
		11/15/86	11/06/86	41040
		08/30/86	08/23/86	41040
		11/09/86	11/08/86	41040
		01/15/86	01/06/86	41040
		09/ /86	09/11/86	41040
		05/24/86	05/16/86	41040
		07/14/86	07/07/86	41040
		04/25/86	04/18/86	41040
		09/12/86	09/05/86	41040
		06/17/86	06/15/86	41040
		08/23/86	08/13/86	41040
		02/18/86	02/11/86	41040

FL 83.2

SEVERE ACUTE HEART DISEASE PATIENTS

HIC #	NAME	DISCHARGE DATE	ADMISSION DATE	PRINCIPLE DIAGNOSIS
[redacted]	[redacted]	01/16/86	01/09/86	41070
[redacted]	[redacted]	10/13/86	10/04/86	41070
[redacted]	[redacted]	03/04/86	02/25/86	41070
[redacted]	[redacted]	11/21/86	11/15/86	41070
[redacted]	[redacted]	11/25/86	11/21/86	41070
[redacted]	[redacted]	05/12/86	05/05/86	41070
[redacted]	[redacted]	04/10/86	04/06/86	41070
[redacted]	[redacted]	08/11/86	08/05/86	41070
[redacted]	[redacted]	12/02/86	11/22/86	41080
[redacted]	[redacted]	05/15/86	05/13/86	41090
[redacted]	[redacted]	02/18/86	02/10/86	41090
[redacted]	[redacted]	11/10/86	10/28/86	41090
[redacted]	[redacted]	02/03/86	01/17/86	41090
[redacted]	[redacted]	07/11/86	07/09/86	41090
[redacted]	[redacted]	11/25/86	11/22/86	41090
[redacted]	[redacted]	01/19/86	01/03/86	41090
[redacted]	[redacted]	12/15/86	12/15/86	41090
[redacted]	[redacted]	02/27/86	02/20/86	41090
[redacted]	[redacted]	08/27/86	08/22/86	41090
[redacted]	[redacted]	03/03/86	02/22/86	41090

FL 83.3

SEVERE ACUTE HEART DISEASE PATIENTS

HIC #	NAME	DISCHARGE DATE	ADMISSION DATE	PRINCIPLE DIAGNOSIS
[redacted]	[redacted]	04/04/86	04/04/86	41040
		10/31/86	10/10/86	41040
		08/11/86	08/03/86	41040
		08/06/86	08/01/86	41040
		04/08/86	03/09/86	41040
		12/12/86	11/30/86	41040
		07/10/86	07/05/86	41040
		12/31/86	12/25/86	41040
		12/21/86	12/13/86	41040
		11/12/86	10/28/86	41040
		03/06/86	02/23/86	41040
		07/31/86	07/22/86	41040
		12/11/86	12/03/86	41040
		09/01/86	08/22/86	41040
		02/03/86	01/28/86	41040
		04/22/86	04/16/86	41040
		09/05/86	08/14/86	41040
		10/15/86	10/10/86	41040
		06/19/86	06/11/86	41040
		06/05/86	05/30/86	41040
		05/01/86	05/01/86	41040

FL 83.4

SEVERE ACUTE HEART DISEASE PATIENTS

HIC #	NAME	DISCHARGE DATE	ADMISSION DATE	PRINCIPLE DIAGNOSIS
[redacted]	[redacted]	06/28/86	06/26/86	41090
		12/10/86	11/29/86	41090
		03/03/86	02/24/86	41090
		10/28/86	10/28/86	41090
		05/23/86	05/06/86	42710
		12/29/86	12/24/86	42710
		05/20/86	05/15/86	42710
		06/02/86	05/21/86	42710
		01/26/86	01/23/86	42710
		02/04/86	01/07/86	42710
		01/20/86	01/16/86	42710
		01/12/86	01/02/86	42710
		05/05/86	04/30/86	42710
		08/30/86	08/28/86	42710
		09/03/86	08/31/86	42710
		02/22/86	02/14/86	42710
		04/19/86	04/18/86	42741
		11/25/86	11/23/86	42741
		03/29/86	03/21/86	42750
		02/28/86	02/27/86	42750
		02/25/86	02/17/86	42750

FL 83.5

SEVERE ACUTE HEART DISEASE PATIENTS

HIC #	NAME	DISCHARGE DATE	ADMISSION DATE	PRINCIPLE DIAGNOSIS
[redacted]	[redacted]	10/25/86	10/25/86	42750
[redacted]	[redacted]	03/15/86	03/14/86	42750
[redacted]	[redacted]	01/03/86	12/32/85	42750
[redacted]	[redacted]	05/02/86	04/19/86	42750
[redacted]	[redacted]	04/30/86	04/21/86	42750
[redacted]	[redacted]	08/13/86	08/08/86	42750
[redacted]	[redacted]	01/21/86	01/16/86	44100
[redacted]	[redacted]	11/26/86	11/17/86	44120
[redacted]	[redacted]	10/26/86	10/13/86	44130
[redacted]	[redacted]	08/04/86	08/03/86	44130
[redacted]	[redacted]	12/20/86	12/19/86	44130
[redacted]	[redacted]	08/17/86	08/13/86	44130
[redacted]	[redacted]	06/11/86	06/10/86	44130
[redacted]	[redacted]	09/12/86	09/12/86	44130
[redacted]	[redacted]	01/29/87	12/28/86	44130
[redacted]	[redacted]	10/14/86	10/05/86	44130
[redacted]	[redacted]	01/29/86	01/29/86	44130
[redacted]	[redacted]	02/04/86	02/02/86	44190

FL 83.6

SEVERE ACUTE HEART DISEASE PATIENTS

HIC #	NAME	DISCHARGE DATE	ADMISSION DATE	PRINCIPLE DIAGNOSIS
[redacted]	[redacted]	03/15/86	03/15/86	41000
		03/08/86	02/23/86	41000
		05/15/86	05/10/76	41000
		02/10/86	01/28/86	41000
		03/19/86	03/18/86	41010
		05/10/86	05/03/86	41010
		05/31/86	05/24/86	41010
		11/14/86	11/03/86	41010
		02/14/86	02/06/86	41010
		06/02/86	06/01/86	41010
		09/02/86	08/30/86	41010
		04/24/86	04/13/86	41010
		11/07/86	11/03/86	41010
		08/08/86	07/31/86	41010
		11/10/86	11/07/86	41010
		09/09/86	08/30/86	41010
		10/07/86	09/17/86	41010
		12/31/86	12/21/86	41010
		07/01/86	06/23/86	41010
		02/10/86	02/01/86	41010
		10/13/86	10/11/86	41010

FL 8'3. 7

SEVERE ACUTE HEART DISEASE PATIENTS

HIC #	NAME	DISCHARGE DATE	ADMISSION DATE	PRINCIPLE DIAGNOSIS
[redacted]	[redacted]	10/29/86	10/23/86	41010
		10/27/86	10/20/86	41010
		02/06/86	02/04/86	41010
		12/19/86	11/22/86	41010
		07/21/86	07/11/86	41010
		07/25/86	07/14/86	41010
		12/22/86	12/07/86	41010
		05/17/86	05/06/86	41010
		10/07/86	09/29/86	41010
		03/15/86	03/11/86	41010
		04/08/86	03/30/86	41010
		07/01/86	06/27/86	41010
		08/25/86	08/14/86	41010
		04/06/86	03/26/86	41010
		11/18/86	10/31/86	41010
		06/21/86	06/09/86	41010
		01/29/86	01/19/86	41020
		05/27/86	05/26/86	41020
		01/15/86	01/03/86	41020
		05/04/86	04/23/86	41020
		08/15/86	08/07/86	41020

FL 83.8

SEVERE ACUTE HEART DISEASE PATIENTS

HIC #	NAME	DISCHARGE DATE	ADMISSION DATE	PRINCIPLE DIAGNOSIS
[redacted]	[redacted]	04/13/86	04/11/86	41040
		09/22/86	09/22/86	41040
		08/29/86	08/18/86	41040
		10/31/86	10/22/86	41040
		10/28/86	10/22/86	41050
		04/17/86	04/03/86	41050
		05/08/86	04/19/86	41050
		12/24/86	12/26/86	41050
		11/24/86	11/18/86	41050
		04/14/86	04/01/86	41050
		01/22/86	01/13/86	41050
		10/15/86	10/14/86	41050
		12/06/86	11/29/86	41050
		01/25/86	01/18/86	41050
		07/25/86	07/20/87	41060
		08/15/86	08/10/86	41060
		02/22/86	02/14/86	41070
		07/29/86	07/21/86	41070
		12/02/86	11/24/86	41070
		12/07/86	11/30/86	41070
		01/31/86	01/26/86	41070

FL 83.9

HCA Medical Center of Port St. Lucie

MEDICARE MORTALITY RESPONSE
HOSPITAL = 10-0260

Quality health care for our patients has been and will remain the primary goal of the Board of Trustees, medical staff, and hospital staff of HCA Medical Center of Port St. Lucie. We acknowledge and support the public's right to obtain and use information that allows them to make informed choices about their health care.

With reference to the mortality rates released by the Health Care Financing Administration in this report, it is important the public be aware that mortality figures alone do not offer an adequate measure of quality patient care.

This raw data is more appropriately used as a component of a hospital's comprehensive quality review process, where variables (such as patient age and severity of disease process on admission) that impact these numbers can be evaluated in depth, keeping the numbers in perspective and therefore more meaningful.

A hospital's actual mortality rates may be higher or lower than the predicted rates cited in the report because the patients actually treated in that hospital may differ from the patients treated in the "average" hospital. For example, when an unusually high percentage of a facility's admissions are emergency admissions, the severity of illness and mortality rate of those patients is higher than patients admitted electively to another facility with the same diagnoses but in a less critical state. In addition, when a hospital serves a community where a majority of the patients are over 65 years of age, the incidence of high mortality diseases such as cancer and heart disease that are prevalent in this population group, adds a bias to the raw mortality data.

Because of the inability of the Health Care Financing Administration's model to take these and other variables into consideration, and the fact that mortality data is only one facet of a hospital's quality review activities, the mortality data presented in this report cannot be used to measure a facility's quality of patient care.

Rather than focusing on one aspect of the quality review process, HCA Medical Center of Port St. Lucie has established a comprehensive process that examines a large number of quality indicators, a process which has been validated by our full accreditation by the Joint Commission on Accreditation of Health Care Organizations. This process involves concurrent and retrospective monitoring of the quality and appropriateness of patient care and the performance of all individuals with clinical privileges as well as mortality review.

1800 S.E. Tiffany Avenue
Port St. Lucie, Florida 33452
Telephone (305) 335-4000
A Subsidiary of HCA The Healthcare Company

Areas of review include all surgical cases, drug usage, blood usage, medical records review, pharmaceutical services, and more. Ongoing monitoring and evaluation is performed in all clinical departments, including the hospital-wide functions of infection control, utilization management and risk management. Important aspects of care are identified, information is screened and the results are evaluated using objective criteria. All findings, recommendations, actions and results are reported and communicated appropriately via monthly medical staff, administration and department meetings. Corrective actions include, but are not limited to, policy changes, procedure changes, structural and equipment modifications, targeted educational programs and, if necessary, appropriate disciplinary measures. A reevaluation process is in place to assure improvement in patient care and resolution of any concerns.

Organizations such as the Joint Commission and the American Hospital Association are continually investigating methods of evaluating hospital quality that rely on measures other than mortality rates. We look forward to the results of such efforts and are supportive of them.

Our commitment to high quality health care for our patients is absolute, and is evidenced by the strong quality review process at work at HCA Medical Center of Port St. Lucie.

COMMENTS ON THE HCFA MORTALITY DATA

NORTH OKALOOSA MEDICAL CENTER, CERSTVIEW, FLORIDA

The data used by HCFA indicate that a total of 696 Medicare patients were admitted to North Okaloosa Medical Center in 1986 and 62 (9%) of the patients died within 30 days of the admission. Our records indicate that 1323 patients were admitted and using your statistic of 62 places the death rate at 5%.

James Rogers, Administrator
North Okaloosa Medical Center

10/21/87

HENDRY GENERAL HOSPITAL
524 WEST SAGAMORE STREET
CLEWISTON, FLORIDA 33440
813/983-9121

MICHAEL M. WARTELLA
ADMINISTRATOR

October 26, 1987

Department of Health&Human Services
Health Care Financing Administration
6325 Security Blvd
Baltimore, Maryland 21207

Medicare Provider # 100098

Dear Administrator:

The information requested regarding mortality rate is as follows;

Patient [redacted] Age - 65,our records indicate age 62.

Patient [redacted] Discharge date listed as 5/25/87, our records indicate 5/26/86.

Patient [redacted] Age - 59,our records indicate age 56.

Patient [redacted] Our reccords indicate [redacted]

Patient [redacted] Death certificate is not available for verification.

Patient [redacted] Death certificate is not available for verification.

Hope this information will assist you in your study.

Sincerely,

Micheal M. Wartella Jr.

Micheal M. Wartella
Administrator

REPORT 1

HOSPITAL MORTALITY RATE COMPARED WITH REGIONAL MORTALITY RATES
FOR THE HOSPITAL'S TOP 50 DIAGNOSIS RELATED GROUPS

HENDRY GENERAL HOSPITAL
CLEWISTON, FLORIDA
JANUARY - DECEMBER 1986

MEDICARE PATIENTS

		<----------HOSPITAL---------->			<----------REGION---------->			MORTALITY RATIO (ACTUAL/EXPECTED)	
DRG	DRG TITLE	ACTUAL DEATHS	ACTUAL CASES	EXPECTED DEATHS	ACTUAL DEATHS	ACTUAL CASES	EXPECTED DEATHS	HOSPITAL	REGION
127	HEART FAILURE, SHOCK	6	50	4.917536	597	5512	555.174958	1.220	1.075
014	CEREBROVASC DX X TIA	5	28	4.856316	717	4088	687.113251	1.030	1.043
129	UNEXPLAINED HEART ARREST	2	2	1.663115	88	118	87.270702	1.203	1.008
082	RESPIRATORY NEOPLASMS	1	8	2.285265	410	1517	413.772029	0.438	0.991
140	ANGINA PECTORIS	1	51	0.311894	42	4136	24.559361	3.206	1.710
263	SKN GRFT, ULC,CELLUL +	1	1	0.069262	26	409	26.715422	14.438	0.973
403	LYMPHOMA,LEUKEMIA +	1	1	0.245737	138	602	121.521941	4.069	1.136
413	OTH MYELOPROLIF DX +	1	2	0.885472	120	280	119.340676	1.129	1.006

AG = AGE 17 OR MORE
X = EXCEPT
+/G = AGE 70 OR MORE AND/OR COMPLICATION OR COMORBIDITY
PA = AGE 0-69 WITHOUT COMPLICATION
+ = WITH COMPLICATION OR COMORBIDITY

FL 98.1

REPORT 2

HOSPITAL MORTALITY RATE COMPARED WITH REGIONAL MORTALITY RATES
FOR THE HOSPITAL'S TOP 50 DIAGNOSIS RELATED GROUPS

HENDRY GENERAL HOSPITAL
CLEWISTON, FLORIDA
JANUARY - DECEMBER 1986

NON - MEDICARE PATIENTS

		<----------HOSPITAL---------->			<----------REGION---------->			MORTALITY RATIO (ACTUAL/EXPECTED)	
DRG	DRG TITLE	ACTUAL DEATHS	ACTUAL CASES	EXPECTED DEATHS	ACTUAL DEATHS	ACTUAL CASES	EXPECTED DEATHS	HOSPITAL	REGION
202	CIRR, ALCOHOL HEPATITIS	2	6	0.674515	69	449	52.874950	2.965	1.305
014	CEREBROVASC DX X TIA	1	12	1.672387	244	1606	202.318397	0.598	1.206
064	CA, ENT	1	1	0.178137	18	186	22.509074	5.614	0.800
078	PULMONARY EMBOLISM	1	2	0.135174	9	324	14.472088	7.398	0.622
082	RESPIRATORY NEOPLASMS	1	2	0.567069	328	1310	337.753246	1.763	0.971
140	ANGINA PECTORIS	1	65	0.116256	2	1934	3.027284	8.602	0.661
205	LIVER DX X CA, CIRR +	1	1	0.131385	60	429	57.766391	7.611	1.039
398	RETICULO, IMMUN DX +	1	2	0.234450	28	284	33.078565	4.265	0.846

AG = AGE 17 OR MORE
X = EXCEPT
+/G = AGE 70 OR MORE AND/OR COMPLICATION OR COMORBIDITY
PA = AGE 0-69 WITHOUT COMPLICATION
+ = WITH COMPLICATION OR COMORBIDITY

REPORT 3

HOSPITAL MORTALITY RATE COMPARED WITH REGIONAL MORTALITY RATES
BY AGE, SEX, RACE, AND ADMISSION SOURCE

HENDRY GENERAL HOSPITAL
CLEWISTON, FLORIDA
JANUARY - DECEMBER 1986

ALL PATIENTS

	<----------HOSPITAL---------->			<----------REGION---------->			MORTALITY RATIO (ACTUAL/EXPECTED)	
DEMOGRAPHICS	ACTUAL DEATHS	ACTUAL CASES	EXPECTED DEATHS	ACTUAL DEATHS	ACTUAL CASES	EXPECTED DEATHS	HOSPITAL	REGION
AGE GROUPS:								
LESS THAN 1 YEAR	0	6	0.292922	861	64386	567.385327	0.000	1.517
1 TO 19 YEARS	0	155	0.234726	289	49230	282.067694	0.000	1.025
20 TO 44 YEARS	2	622	5.452917	1032	160009	1201.214877	0.367	0.859
45 TO 64 YEARS	7	455	8.046874	3336	102972	2881.475856	0.870	1.158
65 TO 74 YEARS	11	320	16.398115	3685	62731	3485.497216	0.671	1.057
75 YEARS OR MORE	8	215	19.450107	4955	53949	4657.613081	0.411	1.064
UNRECORDED	0	0	0.000000	1	32	0.000000	0.000	0.000
SEX:								
MALE	15	955	27.226235	7272	206780	6406.150515	0.551	1.135
FEMALE	13	817	22.628743	6883	286495	6665.991129	0.574	1.033
UNRECORDED	0	1	0.020683	4	34	3.112407	0.000	1.285
RACE:								
WHITE	19	1044	33.747535	9889	359458	9533.460798	0.563	1.037
BLACK	8	656	14.789610	3985	120009	3274.346305	0.541	1.217
ASIAN	0	2	0.004090	16	960	13.059317	0.000	1.225
HISPANIC	1	68	1.312585	68	5386	77.240576	0.762	0.880
OTHER OR UNRECORDED	0	3	0.021841	201	7496	177.147055	0.000	1.135
ADMISSION SOURCE:								
OTHER ACUTE FACILITY	0	0	0.000000	1435	15508	909.931988	0.000	1.577
SKILLED NURSING FACILITY	6	69	7.232922	397	2561	235.414023	0.830	1.686
ALL OTHER	22	1704	42.642739	12327	475240	11929.908040	0.516	1.033
TOTAL:	28	1773	49.875661	14159	493309	13075.254051	0.561	1.083

FL 98.3

HOLLYWOOD
MEDICAL CENTER
3600 Washington Street
Hollywood, Florida 33021
Telephone (305) 966-4500
A SUBSIDIARY OF NATIONAL MEDICAL ENTERPRISES INC

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper,

The attached pages are Hollywood Medical Center's response to the Mortality Statistics for 1986, which are to be published in December, 1987.

We appreciate the opportunity to respond in this manner.

Sincerely,

Josef Silberstein
Chief Executive Officer

JS:ns

cc: Harvey Brook
Health Standard & Quality Bureau
Room 2D2 Meadows East Bldg
6300 Security Blvd.
Baltimore, MD. 21207

Hospital # 100-225

HOLLYWOOD
MEDICAL CENTER
3600 Washington Street
Hollywood, Florida 33021
Telephone (305) 966-4500
A SUBSIDIARY OF NATIONAL MEDICAL ENTERPRISES INC

RESPONSE - 1986 MORTALITY STATISTICS

Hollywood Medical Center is a short-term, acute care hospital geographically situated in a neighborhood populated predominantly by retired, elderly individuals. The hospital does not treat obstetric, newborn or pediatric patients. This combination of circumstances results in a higher-than-average elderly patient population, which is defined as greater than 75 years of age, and when patients reach this point, many of them have multiple chronic, serious health problems.

In review of the 262 mortality cases presented by HCFA, it was found that 78% were patients who were greater than 75 years of age and 12% were greater than 70 years of age.

Sixteen categories of diagnoses were included in the HCFA report. Hollywood Medical Center fell well within the predicted range of mortality rates in fifteen of those categories. The single category in which this hospital fell outside the HCFA predicted mortality rate was in the area of Gastrointestinal Diseases, (not to be confused with Gastrointestinal Catastrophies). The actual percentage exceeded the predicted range by only 1%, or 2 cases.

An in depth review of the 23 cases included in this category revealed that some of these cases would have been more properly placed in the Gastrointestinal Catastrophy section, i.e., 2 cases wherein the gastrointestinal problem was of an extreme severity, not indicated by the diagnostic category. These two cases, inappropriately classified, reduce Hollywood Medical Center's Mortality Rate in this category to the predicted range.

This review revealed that seven of the patients and/or family requested that no extraordinary life-saving measures be taken. Six patients, in addition to the gastrointestinal complaint for which they were admitted, had overwhelming infections due to pneumonia and septicemia. Two patients suffered a sudden cerebrovascular accident or an acute myocardial infarction while hospitalized. One patient had refused to seek medical treatment for his condition for three weeks prior to admission and expired eight hours thereafter. One patient had persistently refused, over three different hospitalizations, to follow medical advice and had demanded discharge against medical advice on two occasions. It should be further mentioned that all (100%) of the cases in this category had multiple medical conditions which had a negative impact on treatment of the gastrointestinal condition. Seven of these patients were over 85 years of age.

HOLLYWOOD
MEDICAL CENTER
3600 Washington Street
Hollywood, Florida 33021
Telephone (305) 966-4500
A SUBSIDIARY OF NATIONAL MEDICAL ENTERPRISES INC

In attempting to analyze a hospital's mortality rate, it should be understood that the patients included in the study are placed in their respective categories according to the principal diagnosis which is defined as the reason established, after study, to be chiefly responsible for admission to the hospital. Therefore, the patients having severe heart conditions, malignancies, chronic lung diseases or strokes which were actually responsible for their deaths, were included in the gastrointestinal category. It should be further understood that HCFA's data also includes deaths within 30 days of admission to the hospital, regardless of the cause of death. For example, in the gastrointestinal disease category, eight of the patients died after discharge; all were discharged in stable condition relative to the gastrointestinal complaint for which they were admitted, four were discharged home, three to a nursing home and one to hospice, the latter, obviously, by virtue of disposition, were in an advanced stage of illness.

Extensive review of all deaths is performed at Hollywood Medical Center, by physicians of the appropriate medical speciality. Additionally, this hospital has a strong Quality Assurance Program to oversee the quality of care on a concurrent basis. All hospitals are required to adhere to a stringent set of standards of care in order to be licensed by the county and the state. Hospitals also voluntarily undergo inspection by the Joint Commission on Accreditation of Hospitals which also applies rigorous standards prior to granting its endorsement.

Sincerely,

Josef Silberstein
Chief Executive Officer

JS:ns
cc: Frank Tidikis

Holmes Regional
Medical Center, Inc.

October 26, 1987

William Roper, M.D.
Administrator
Health Care Finance Administration
Department of Health & Human Services
Washington, DC 20201

Dear Sir:

This is a formal reply to the mortality data that the Health Care Finance Administration will be releasing later this year to the general public. While Holmes Regional Medical Center statistics are well within the range of predictable mortality rates, we felt it was important to attempt to verify the data that will soon be released, and to inform you of several discrepancies and/or problems that we found in reviewing this information.

The data used by HCFA indicates that 481 Medicare patients admitted to Holmes Regional Medical Center died within 30 days of admission. Of these patients, 386 died while remaining as inpatients at the Medical Center, and 95 died following discharge from the hospital. Our own records indicate that we actually had 444 Medicare patients that eventually died as inpatients in our hospital. Therefore, a discrepancy may exist between your listing and our records. Sixty-six persons were listed as expired on our patient discharge listing, but these were not included on your list. These 66 patients were found in the following diagnostic groupings: CA 18; CE 6; GC 1; GI 6; HL 1; HM 7; HS 10; ME 1; PN 8; RN 1; SE 3; and UN 4.

Since the hospital did not receive payment from the Medicare program on 22 of these patients, that may explain why their names were deleted from the HCFA listing. Thus, it appears that another 44 persons should have been included in the listing, but were inexplicably deleted. We are concerned that the data that is about to be released by HCFA will neither be verified nor totally verifiable, based on discrepancies already outlined above. As I am sure you are aware, the potential damage that this could cause by the publication of such erroneous information could be tremendous, and the misinformation spread indiscriminately among the general public will not be easily corrected later. Furthermore, the mortality data does not explain to the public that hospitals monitor other quality indicators than just

1350 South Hickory Street
Melbourne, Florida 32901
(305) 676-7171

VHA
Member of Voluntary Hospitals of America, Inc.

statistics relating to the patient's last admission. Additionally, we remain concerned that the release of mortality data, which includes deaths occurring after patients have been discharged from the hospital, will add further to the confusion and misinformation.

Should there be any further information or assistance that we could provide, please feel free to contact us.

Sincerely,

Kirk H. Gray
Senior Vice President/
Chief Operating Officer

KHG/bje

996 Airport Road
Destin, Florida
32541
Telephone 904 654-7600

Humana Hospital
Destin

October 26, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Destin supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues and recognizes this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality reviews, utilization review, as well as complete review by the Department of Health and Rehabilitative Services.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not particularly meaningful for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be caustioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's quality assurance committee and medical staff have reviewed the data specific to Humana Hospital-Destin. Of the three deaths you reported for our hospital one did not expire while a patient in our facility, the second expired in the Emergency Department after arriving in cardio-pulmonary arrest and the third death was attributed to cancer. Generally, we have found it to be consistant with our hospital records. Unfortunately, the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. Our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Daniel J. Friedrich III

Daniel J. Friedrich III
Executive Director

DJF:jf

Humana Hospital
Bennett

October 23, 1987

The Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, DC 20201

Dear Sir:

Thank you for allowing us the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Bennett supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

These statistics reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome. Thus, they must be considered in that context and should serve only one of numerous indicators used to review the quality of services provided at an individual hospital. This statistical data is useful for professional evaluation but it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers. The public should not draw any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's quality assurance has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

Our hospital is located in an area where there is a large percentage of elderly population and over 50% of our hospital census is Medicare patients. Considering this fact, our statistics fall well within the predicted range of predicted mortality rates.

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

H. Rex Etheredge
Executive Director

HRE/laf

20900 Biscayne Boulevard
Miami, Florida
33180
Telephone 305-932-0250

Humana Hospital Biscayne

October 27, 1987

William L. Roper, M.D.
Administrator, Health Care
Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P. O. Box 26676
Baltimore, Maryland 21201

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital Biscayne supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program, which includes regular and complete review of all admissions that result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve only as one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, these statistics may assist health care consumers in understanding the extensive quality control systems used in hospitals.

Humana Hospital - Biscayne's Quality Assurance Department has reviewed the data supplied. It should be noted that sixty-four out of 336 cases, or 19% of the deaths, had occurred outside the hospital. Thus, we have been unable to completely verify this data. We have, however, found it to be consistent with our own medical records. In some of the categories, the number of patients is too small to provide a valid statistical analysis. Also, the predicted ranges are extremely broad and have been developed in a complex and unverifiable manner. Therefore, it would be inappropriate to consider them acceptable or unacceptable as standards.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Robert M. Krieger
Executive Director

/es

Humana Hospital
Daytona Beach

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us. Humana Hospital-Daytona Beach supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this problem is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outsome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in

identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's quality assurance and medical staff have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

William W. Ward
Executive Director

6000 49th Street North
St Petersburg, Florida
33709
Telephone 813 521-4411

Humana Hospital
Northside

October 23, 1987

William L. Roper, M.D.
Administrator
HCFA
Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Northside supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's Quality Assurance Committee has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with some exceptions with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

Specifically, we reviewed all categories and would like to submit the following information regarding three categories:

1. Sepsis: 28 cases reviewed, 18 deaths, 64% mortality

   A. The average age of the 18 patients was 82 which included a 53 year-old.

   B. 72% were admitted to the hospital from a nursing home.

   C. 100% had sepsis on admission; none had hospital-acquired infections.

   D. 39% were in septic shock on admission.

   E. 100% had other pre-existing conditions such as chronic obstructive pulmonary disease, renal failure, cancer, arteriosclerotic heart disease, dehydration, organic brain syndrome.

   F. 67% of the patients were no code patients (no heroic measures at family's request).

   In summary, the majority of the deaths were in patients who came from nursing homes in a very debilitated state with numerous complicating conditions.

2. Severe Acute Heart Disease: 57 cases reviewed, 29 deaths, 51% mortality

   A. Average age = 75.

   B. 21% came from nursing homes.

   C. 93% had other pre-existing conditions such as renal failure, life-threatening arrhythmias, congestive heart failure.

   D. 21% came to the hospital in cardiogenic shock.

   E. 35% were resuscitated in the field by paramedics and brought to the hospital in a post-code state.

   F. The average length of stay was 2.5 days with 55% expiring in less than 24 hours.

   G. 24% were no codes (no heroic measures at family's request).

   In summary, the majority of the patients had massive heart attacks and expired soon after admission.

3. Severe Chronic Heart Disease: 91 cases reviewed, 37 deaths, 41% mortality

   A. Two patients who expired after discharge died of other causes, specifically metastatic CA and diabetes.

   B. Average age = 78.

   C. 32% came from nursing homes.

   D. 100% had other pre-existing conditions such as chronic obstructive pulmonary disease, renal failure, diabetes, cancer, and hypertension.

   E. 16% were admitted in cardiogenic shock.

   F. 32% were no codes (no heroic measures at family's request).

   In summary, two patients expired of other causes. A significant percentage came to the hospital from a nursing home in advanced states of debilitation and numerous complications.

Overall, Humana Hospital - Northside receives a disproportionate number of its Medicare admissions from nursing homes (20%). In most cases these patients are in advanced states of debilitation with many complicating pre-existing conditions. This would account for a higher than expected mortality rate.

The Quality Assurance Committee found no patterns by physician and were comfortable that proper protocols had been followed in all cases.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Donald A. Shaffett
Executive Director

DAS/sl

1000 Mar-Walt Drive
Fort Walton Beach, Florida
32548
Telephone 904 862-1111

Humana Hospital
Fort Walton Beach

October 27, 1987

William L. Roper, M.D.
Administrator, Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I appreciate the opportunity you have offered to respond to the hospital specific mortality data provided this institution. Humana Hospital - Fort Walton Beach is in support of the efforts of Health Care Financing Administration (HCFA) to educate the public about Medicare quality issues.

The data provided by your office will be used in conjunction with information developed by our hospital's on-going quality assurance program. This program includes, but is not limited to: admission reviews, utilization review, quality assurance, regular morbidity and mortality reviews, and regular independent reviews by outside agencies such as the Joint Commission on Accreditation of Health Organizations.

The statistics on mortality produced by HCFA should serve as only one of numerous indicators to review quality of services provided at an individual hospital. These numbers by themselves do not take into account factors, such as severity of illness, which have an impact on patient outcome. In addition, this data is reflective of only one segment of this hospital's patient population (the elderly). As a result of these limitations, I believe that the mortality data, while useful for professional evaluation, is not beneficial for the healthcare consumer. Consumers should be cautioned about using this data to draw conclusions about a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is needed to determine the appropriateness of the outcome and provide information to practitioners about improvements which can be made in treating future patients. Mortality statistics by themselves are useful to professionals in identifying trends in treatment outcomes.

A review of the data provided was undertaken by our hospital's medical records and quality assurance departments. We are not able to completely validate the data related to deaths which occurred outside the hospital following discharge (25% of the total reported by your office). Overall, we have found it to be consistent with our hospital records. Unfortunately, in most diagnostic categories, the number of patients is too small to allow for valid statistical analysis. In addition, the predicted ranges developed for particular categories are so broad, it would be inappropriate to consider them acceptable or unacceptable "standards".

I hope this information will be useful in your efforts to improve the collection and reporting of hospital data. Humana Hospital - Fort Walton Beach will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

David A. McClellan
Executive Director

DMc:cj

5100 West Hallandale Boulevard
Hollywood, Florida
33023
Telephone 305 966 8100

Humana Hospital
South Broward

October 22, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Humana Hospital-South Broward appreciates the opportunity to comment on the hospital's specific mortality data provided to us last month. Although the Health Care Financing Administration's program to educate people interested in quality issues is in its early development stages, it is recognized that mortality rates may be used by some as a statistical measure of quality.

The Health Care Financing Administration's mortality data for Humana Hospital-South Broward appears to be within predicted ranges, and is one indication of the hospital's commitment to delivering quality care. It should be noted, however, that these raw numbers reflect deaths which occurred in only a limited segment of the hospital's patient population (the elderly) and have not been adjusted for severity of illness or other factors which may effect patient outcome. Consequently, we caution the consumer against making inferences about quality of care provided based solely upon mortality data. Statistical data such as the mortality rates should serve as only one of the numerous indicators used to review the quality of services provided at an individual hospital. Consumers should be informed as to the limited scope of these numbers, and must be cautioned about drawing any conclusions from the data about the quality of the particular hospital services.

As in all deaths occurring in hospitals, a complete review is made to determine the appropriateness of the outcome, and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. However, since the data reflects deaths which occurred within 30 days of admission (whether in the hospital or outside of the hospital), there are obviously some influences beyond the control of a hospital. Specifically, it should be noted that at least 13 people reflected in the study data did not expire while a patient in Humana Hospital-South Broward.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our institution will do everything possible to assist our community in understanding how this data can best be utilized to improve health care services.

Sincerely,

Zeff Ross
Executive Director

ZR/mr

Humana Hospital
Orange Park

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Medicare Provider Number 100226

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital's specific mortality data provided to us late last month. Humana Hospital-Orange Park supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete independent review by the Joint Commission on Accreditation of Healthcare Organizations and other independent review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illnes or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the

limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, an internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records personnel have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Lee R. Ledbetter
Executive Director

LRL:lh
#026b

P.O. Box 835
U.S. Highway 1
Sebastian, Florida
32958
Telephone 305 589 3181

Humana Hospital
Sebastian

October 23, 1987

Dr. Roper
Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 206684
Baltimore, MD 21207

Dear Dr. Roper:

The opportunity to comment on the hospital specific mortality data provided to us late last month is greatly appreciated. Humana Hospital Sebastian supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize that the program is in the developmental stages. While the measurements are preliminary, this data is clearly an example of the type of quality measurements to be provided in the future.

The information provided by the mortality data is helpful in our hospital's ongoing quality assurance program which incorporates regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as, outside review by the Joint Commission on Accreditation of Health Organizations along with other outside review organizations.

Since this raw data reflects deaths which occurred in a limited segment of the hospital's patient population, i.e., the elderly, and is not adjusted for severity of illness or other factors which may affect patient outcome, it must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be clearly informed as to the limited scope of this data, and be cautioned about drawing any conclusions from it about the quality of a hospital's services.

A complete internal review is necessary to determine the appropriateness of the outcome for deaths occurring in the hospital setting. In addition, the internal review may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. The data may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records and quality assurance staff reviewed the data. Some of the deaths apparently occurred outside the hospital, therefore, we have been unable to completely validate this information. In general, we have found the data to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in a rather complex and unverifiable manner so that it would not be appropriate to consider these "standards" as acceptable or unacceptable.

We hope this feedback will assist in the refinement of the collection and reporting of raw hospital data. Our hospital will do everything possible to work with our community in understanding how this data can best be utilized to positively impact health care services in our area.

Sincerely,

Mitchell B. Smith
Executive Director

MBS/dk

6500 38th Avenue North
P. O. Box 13096
St. Petersburg, Florida
33710
Telephone 813 384-1414

Humana Hospital
St. Petersburg

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Re: Humana Hospital - St. Petersburg, Medicare Provider No. 100180

Dear Dr. Roper:

I appreciate the opportunity to comment on the hospital's specific mortality data which was provided to us in late September. Humana Hospital - St. Petersburg supports HCFA's desire to educate those who are interested in Medicare quality issues. We recognize that this program is in its early development stages and that while its measurements are preliminary and rough, it clearly is an example of the type of quality measurements to come.

The information will be helpful in our ongoing quality assurance program that includes the regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance/ utilization review, as well as complete outside review by the Joint Commission on Accreditation of Healthcare Organizations and other outside review organizations.

These raw numbers reflect deaths which occurred in only a limited segment of the hospital's patient population (the elderly). They are not adjusted for severity of illness or other factors which may affect patient outcome. Therefore, they must be considered in that context and should serve as only one of a number of indicators used to review the quality of services provided at this or any other hospital. While the data are useful in the format presented for professional evaluation, they are not beneficial for consumer use. Therefore, consumers should be informed as to the limited scope of the numbers and be cautioned about drawing any conclusions from the data about the quality of a particular hospital services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome. This review may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality

statistics is helpful to health care professionals in identifying patient trends and treatment outcomes. In addition, the statistics may assist health care consumers in understanding the extensive quality control system in place in hospitals.

Hospital management has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to validate these data completely. However, we have found it to be generally consistent with our hospital records. In many cases we believe that the number of patients in a particular category is too small to provide a valid statistical analysis. Additionally, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner that it would be inappropriate to consider them acceptable or unacceptable standards.

We hope that this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how these data can best be used to improve health care services.

Sincerely,

HUMANA HOSPITAL - ST. PETERSBURG

David K. Donin
Executive Director

DKD:mh

Humana Hospital
Sun Bay

U.S. OVERNIGHT MAIL

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Assurance
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: RESPONSE TO HCFA MORTALITY DATA

Dear Sirs:

Enclosed please find our completed response to the mortality data regarding our hospital which HCFA provided to us last month.

Please include our response in your final publication of hospital mortality data.

If you have any comments or questions, please feel free to call me at (813) 823-1122, ext. 300.

Very Truly Yours,

Davide M. Carbone
Executive Director

DMC/st

cc: Patrick Stone
Wood Matthews
Pat Driscoll

HUMANA HOSPITAL - SUN BAY
October, 1987

RESPONSE TO HCFA ON HOSPITAL MORTALITY RATES

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Sun Bay supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues, while recognizing that this program is early in its development stages.

This information is helpful in our hospital's ongoing quality assurance program that already includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance reviews, utilization reviews, as well as complete hospital wide outside review by the Joint Commission on Accreditation of Hospitals and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While the statistical data is useful in this format for professional evaluation, we feel it is not beneficial for consumer use. Therefore, consumers should be informed as to the limited scope and usefulness of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, this information may assist health care consumers in understanding the complexity of such analyses and the extensive quality control systems currently in place in hospitals.

Our hospital's medical records and quality assurance departments have reviewed the data provided by HCFA. Since 17% of those deaths included in the HCFA study occurred outside Humana Hospital - Sun Bay, we have been unable to completely validate this data. Generally, we have found it to be consistent (with some exceptions) with hospital records. Unfortunately, in most cases, the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverificable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

Specifically, we have reviewed all diagnostic categories reported in the study and have identified only one category out of the 16 in which the HCFA reported Actual Mortality Rate exceeded the HCFA Range of Predicted Morality Rates. This is the HM-Severe Chronic Heart Disease category, in which HCFA reported a 41 percent Mortality Rate compared with the predicted range of 14 to 37 percent. Our analysis of this category provided the following summary information.

- Of the 54 cases reviewed, 22 (41 %) died within 30 days of admission.

- The average age of the patient in this disease category was 85.5 years of age, with 13 (59 %) of these 22 patients being 85 years of age or <u>older.</u>

- 16 (73%) of the 22 patients lived in a nursing home prior to hospitalization.

- 2 (9%) of the 22 patients died <u>after</u> discharge from the hospital. Both patients were discharged to nursing homes and both patients had diagnoses which included other major organ systems in addition to the heart.

- 20 (91%) of the 22 patients died while a patient at the hospital and have the following characteristics:

  . 15 (75%) were an anticipated death with "DO NOT RESUSITATE" orders.

  . 3 (15%) were an anticipated death with resusitate orders.

  . 19 (95%) had diagnoses which included diseases of major organ system in addition to the heart.

  . 10 (50%) of the deaths were due to causes other than or in addition to heart disease.

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data and demonstrate the assortment of other relevent information and mitigating factors which were not reported in the HCFA data. In addition, our hospital will do everything possible to assit our community in understanding how this data can best be used to improve health care services.

Imperial Point Medical Center

6401 North Federal Highway
Fort Lauderdale, Florida 33308
305/776-8501

Thomas J. Corder
Administrator

October 27, 1987

Mr. Harvey Brooks
Special Assistant
Health Care Financing Administration
Health Standard and Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, Maryland

Re: Imperial Point Medical Center
Provider Number 1000200

Dear Mr. Brooks:

Attached hereto are our comments as they pertain to the mortality information received in your letter of September 21, 1987. We appreciate the opportunity to express our comments and concerns as to the meaningful use of this information.

Sincerely,

Philip J. Noel, III
Assistant Administrator

PJN:das

Enclosure

A Facility of
North Broward
Hospital District

COMMENTS TO HEALTH CARE FINANCING ADMINISTRATION

MORTALITY INFORMATION

We would like to preface our comments with the fact that we too agree with William L. Roper, M.D., Administrator, Health Care Financing Administration, as stated in his letter of September 21, 1987, that the "information on its own is not a complete measure of the quality of care at an individual hospital." Mortality information can be easily misinterpreted, especially when you review only that portion of the patient population, 65 years or older, which is prone to multiple health problems. Therefore, the use of this data as a "consumer guide" for measuring the quality of care provided by any institution would be inappropriate. Imperial Point Medical Center is aware that the Joint Commission on Accreditation of Healthcare Organization is developing a model quality of care indicator. We, like so many hospitals across the nation, support this effort and look forward to the implementation of this tested methodology in the future.

After reviewing the information provided by the Health Care Financing Administration (HCFA), we found one case in which a patient was treated and released from the hospital, but according to the HCFA data, this patient had expired four months prior to being admitted to Imperial Point Medical Center. Additionally, it should be noted that twenty-five (25) percent of the reported deaths occurred after discharge from the hospital. Verification of these dates of expiration could not be verified at this time. We also observed that in some diagnostic categories, there was an insufficient number of cases to make any type of meaningful prediction or comparison.

As previously mentioned the use of Mortality Data alone cannot be used to evaluate the overall quality of care provided by an institution. The information does not take into account how ill the patient was at the time of admission and other factors which contribute to a patient's course of treatment in a hospital setting. Further review of our records indicated that fifty-eight (58) percent of reported mortalities were classified as terminally ill patients with a poor prognosis, and in fifty-four (54) percent of the reported mortalities, the patient or family had requested that no heroic efforts be made to prolong life. Additionally, we found that seventy-three (73) percent of the patients had four or more conditions which contributed to their illness. We also found that some patients were discharged to a Hospice setting, and still others came to us from a nursing home or other setting in an acute stage of illness.

Mortality information by itself is not an effective tool to judge the quality of care provided. Only after all factors, such as the severity of illness, are reviewed can a more accurate mechanism (such as the one under development by the Joint Commission on Accreditation of Healthcare Organizations) be used as an indicator of the quality of care provided in a hospital setting.

Provider Number: 1000200

JACKSON MEMORIAL HOSPITAL
1611 N.W. 12th AVENUE • MIAMI, FLORIDA 33136

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Hospital Mortality Data

Gentlemen:

We have reviewed the hospital mortality data published by your department.

Enclosed are our comments pertaining to this data, and we feel that these comments should be considered and included whenever this data is provided to the media.

Sincerely,

Charles Hilsenbeck
Medical Statistician
Quality & Utilization
Management Department

/gc

att.

OUR ANALYSIS OF THE HCFA DATA AS PUBLISHED INDICATED A HIGHER THAN EXPECTED PROBABILITY OF DEATH IN TWO OF THE DISEASE CATEGORIES, SEPSIS AND LOW-RISK GASTROINTESTINAL DISEASE. IN THE LOW-RISK HEART DISEASE CATEGORY, THE PUBLISHED MORTALITY RATE IS WITHIN THE EXPECTED INTERVAL, BUT AT THE UPPER LIMIT. AFTER A THOROUGH REVIEW OF THE CASES IN THESE GROUPS, AS WELL AS THE PRINCIPAL MEDICAL DIAGNOSES THAT PLACE A PATIENT IN THESE GROUPS, WE FEEL THAT THE FOLLOWING COMMENTS ARE REQUIRED FOR A CLEAR UNDERSTANDING AND INTERPRETATION OF THESE DATA.

ROLE AS PUBLIC TEACHING HOSPITAL:

JACKSON MEMORIAL IS A LARGE PUBLIC TEACHING HOSPITAL THAT SERVES A WIDELY VARYING PATIENT POPULATION. PART OF THE MISSION OF JACKSON IS TO PROVIDE HEALTHCARE TO ALL DADE COUNTY CITIZENS REGARDLESS OF THE ABILITY TO PAY. JACKSON ALSO FUNCTIONS IN THE ROLE OF A REGIONAL REFERRAL CENTER FOR ALL OTHER HOSPITALS FOR DIFFICULT AND EXTREMELY ACUTE CASES OF ALL TYPES, ESPECIALLY FOR TREATMENT OF EMERGENCY CONDITIONS AND TRAUMA. AS A RESULT, MANY PATIENTS THAT ARE SEEN AT JACKSON ARE CRITICALLY OR TERMINALLY ILL AND HAVE A POOR PROGNOSIS. THIS INCLUDES MEDICARE PATIENTS, PARTICULARLY THOSE THAT EITHER LIVE ALONE, HAVE HAD LITTLE OR NO PAST MEDICAL TREATMENT AND ARE CHRONICALLY ILL, OR ARE RESIDENTS OF NURSING HOMES AND OTHER NURSING FACILITIES. MANY MEDICARE PATIENTS ARE TRANSFERRED TO JACKSON FROM OTHER ACUTE-CARE HOSPITALS FOR VERY SPECIALIZED TREATMENT OF SEVERE LONG-TERM HEALTH PROBLEMS.

IN THE HCFA ANALYSIS OF MORTALITY RATES, FEW IF ANY OF THE ABOVE FACTORS ARE TAKEN INTO ACCOUNT BY THE STATISTICAL MODEL USED TO GENERATE THE NUMBERS THAT ARE CENTRAL TO THE HCFA STUDY. THE FACTORS THAT ARE INCORPORATED INTO THE MODEL CONSIST OF AGE, SEX, TRANSFER STATUS, PRIOR HOSPITILIZATIONS AND NO MORE THAN 3 COMPLICATING OR COMORBID CONDITIONS. MAJOR FACTORS THAT ARE ABSENT FROM THE MODEL ARE THE SEVERITY OF THE CONDITION OR ILLNESS, MODE OF ADMISSION TO THE HOSPITAL (EMERGENCY OR NURSING HOME ADMISSIONS), SALIENT ASPECTS ABOUT THE PAST MEDICAL HISTORY OF THE PATIENT, WHETHER THE PATIENT WAS ADMITTED TO THE HOSPITAL FOR TERMINAL CARE OR IF NO ACTION TO PROLONG LIFE WAS REQUESTED BY THE PATIENT OR THE FAMILY.

PATIENT POPULATION:

THE TYPICAL MEDICARE PATIENT CONTAINED IN THE HCFA ANALYSIS WAS 72 YEARS OF AGE WITH AN AVERAGE OF 5 LIFE-THREATENING COMPLICATING CONDITIONS. APPROXIMATELY 70% OF ALL CASES WERE ADMITTED TO JACKSON ON AN EMERGENCY BASIS AND IN ALMOST HALF OF ALL OF THE CASES, WHETHER EMERGENCY ADMISSIONS OR NOT, EITHER THE FAMILY OR THE PATIENT REQUESTED NO ACTION BE TAKEN TO PROLONG LIFE.

THE TYPICAL SEPSIS PATIENT IN THE HCFA SAMPLE WAS 79 YEARS OF AGE AND HAD AN AVERAGE OF 6 LIFE-THREATENING COMPLICATING CONDITIONS IN ADDITION TO SEPSIS. NINETY PERCENT OF THE CASES WERE EMERGENCY ADMISSIONS TO THE HOSPITAL WITH A POOR PROGNOSIS AND NO ACTION TO PROLONG LIFE WAS REQUESTED BY EITHER THE FAMILY OR THE PATIENT IN 70% OF THE SEPSIS CASES.

THE TYPICAL LOW-RISK GASTROINTESTINAL DISEASE PATIENT IN THE HCFA SAMPLE WAS 70 YEARS OF AGE WITH 5 ADDITIONAL LIFE-THREATENING COMPLICATING CONDITIONS. OVER HALF OF THESE PATIENTS HAD A DOCUMENTED HISTORY OF LONG-TERM ALCOHOL ABUSE THAT RESULTED IN CIRRHOSIS OF THE LIVER. A TOTAL OF 64% OF THE CASES WERE EMERGENCY ADMISSIONS TO JACKSON AND NO ACTION TO PROLONG LIFE WAS REQUESTED IN HALF OF THE CASES. MAJOR ABDOMINAL SURGERY WAS PERFORMED ON AN EMERGENCY BASIS IN APPROXIMATELY 60% OF THESE LOW-RISK DISEASE PATIENTS.

CLASSIFICATION PROBLEMS:

WE FEEL THAT HCFA MUST CORRECT SEVERAL ERRORS IN THE MORTALITY DATABASE BEFORE RELEASING THESE DATA TO THE PUBLIC. ATTACHED IS A LIST OF 5 ERRORS DETECTED IN A REVIEW OF 37 MEDICAL RECORDS. IN TWO CASES IN THE LOW-RISK HEART DISEASE CATEGORY, PATIENTS WERE COUNTED ERRONEOUSLY AS DEATHS. ONE PATIENT WAS TRANSFERRED TO ANOTHER HOSPITAL FOR SCHEDULED CARDIAC SURGERY AND DIED AFTER TRANSFER. A SECOND CASE NEVER DIED AND HAS BEEN SEEN AT JACKSON AS RECENTLY AS JULY OF 1987. IN ANOTHER CASE, AN INCORRECT PRIMARY DIAGNOSIS WAS USED AT HCFA FOR A CARDIAC PATIENT LEADING TO THE MISCLASSIFICATION OF THE CASE INTO THE LOW-RISK HEART DISEASE CATEGORY INSTEAD OF THE CORRECT SEVERE ACUTE HEART DISEASE CATEGORY. ADDITIONALLY, ACCORDING TO OUR REVIEW, HCFA USED THE PENULTIMATE, NOT THE LAST ADMISSION FOR A PATIENT WHICH RESULTED IN THE MISCLASSIFICATION OF THE CASE INTO THE LOW-RISK GASTROINTESTINAL DISEASE CATEGORY.

OUR ANALYSIS SHOWS THAT THESE ERRORS HAVE SIGNIFICANT IMPACT ON THE OBSERVED MORTALITY RATES REPORTED IN THE HCFA STUDY AND MUST BE CORRECTED PRIOR TO THE RELEASE OF THESE DATA. ADDITIONALLY, THERE IS STRONG DISAGREEMENT BY THE MEDICAL STAFF ABOUT THE APPROPRIATENESS OF MANY PRINCIPAL DIAGNOSES BEING DESIGNATED AS LOW-RISK CONDITIONS. FOR EXAMPLE BLOOD IN THE STOOL (MELENA), IS DESIGNATED AS A LOW-RISK DIAGNOSIS, BUT DEPENDING ON THE SEVERITY OF THE CONDITION, CAN BE LIFE-THREATENING AND QUICKLY FATAL.

STATISTICAL CONCERNS:

IT IS UNFORTUNATE THAT HCFA DID NOT INCLUDE THE LOGISTIC REGRESSION MODEL AND THE ACTUAL REGRESSION COEFFICIENTS WITH THE MORTALITY DATA FOR HOSPITAL REVIEW. THE EFRON BOOTSTRAP METHOD, THOUGH THEORETICALLY ELEGANT, IS FAR FROM A PROVEN STATISTICAL METHOD FOR DEALING WITH EPIDEMIOLOGICAL STUDIES OF THIS TYPE. WE WOULD APPRECIATE THE OPPORTUNITY TO EVALUATE THE HCFA MODEL IN A RIGOROUS FASHION AND TO THEN BE ALLOWED TO COMMENT ON THE ACTUAL NUMERICAL METHODS AND THE ADEQUACY OF THE NUMBER OF ITERATIONS USED TO GENERATE THE MORTALITY PARAMETER AND THE TOLERANCE INTERVALS.

IN SUMMARY, WE FEEL THAT THE VALIDITY OF THE HCFA STUDY IS BASED PRIMARILY ON THE SEQUENCE OF CODING OF DIAGNOSES THAT ARE SUBMITTED TO MEDICARE AND THAT APPROACH DOES NOT REFLECT ACCURATELY THE ENTIRE NATURE OF THE "AVERAGE" OR "TYPICAL" MEDICARE PATIENT TREATED AT JACKSON. IN FACT IF THE CODED DIAGNOSES FOR JACKSON PATIENTS WERE TO BE RESEQUENCED BY ANY OF SEVERAL SOPHISTICATED COMPUTER PROGRAMS, ALL OF THE OBSERVED MORTALITY RATES FOR JACKSON WOULD FALL WITHIN THE HCFA PREDICTED RANGES. WE BELIEVE THAT HOSPITALS SHOULD BE EVALUATED ON THE QUALITY OF MEDICAL CARE PROVIDED TO PATIENTS AND NOT ON THE QUALITY OF MEDICAL RECORD CODING.

SUMMARY OF INFORMATION RELATED TO H.C.F.A. MORTALITY DATA.

HIC NUMBER	PATIENT	GROUP	PROBLEM	CORRECTION
[redacted]		HL	PATIENT ALIVE; LAST SEEN AT JMH CLINIC ON 07/01/87.	REMOVE CASE FROM MORTALITY DATA.
[redacted]		HL	WRONG PRIMARY DIAGNOSIS LEADING TO MIS-CLASSIFICATION IN LOW-RISK HEART DISEASE GROUP	CORRECT PRIMARY DIAGNOSIS = 427.0, NOT 427.89.
[redacted]		HL	PATIENT TRANSFERRED ALIVE TO MIAMI HEART INST. FOR CARDIAC SURGERY.	REMOVE CASE FROM MORTALITY DATA.
[redacted]		HL	WRONG DATE OF DEATH USED.	CORRECT DATE = 06/14/86
[redacted]		BI	HCFA USED PENULTIMATE ADMISSION, NOT LAST ADMISSION, LEADING TO MISCLASSIFICATION	CORRECT ADMISSION = 03/20/86, WITH PRIMARY DIAGNOSIS = 576.0.



JACKSONVILLE MEDICAL CENTER

September 28, 1987

William L. Roper, M. D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Doctor Roper:

The Quality Assurance Committee of this hospital has reviewed the Hospital Mortality Information recently sent to us for 1986.

Because our actual mortalities for fifteen (15) of the Diagnostic Categories were considerably below your upper limits, we will comment only on the one (1) area in which we were 7% above your upper limit--renal disease.

As will be seen, our mortality rate was based on only 5 cases. These patients are nursing home residents who are known end-stage renal disease and who were admitted to us from the nursing facilities in moribund condition beyond the help of renal dialysis or other emergency measures. We believe that our acceptance of these nursing home patients inflated our death rate for this category.

We appreciate this opportunity to comment on these statistics prior to their December publication.

Sincerely,

Kenneth W. Jones, M. D., Chairman
Quality Assurance Committee

Medicare Provider Number: 100196

KWJ/lg

4901 Richard Street
P. O. Box 10398
Jacksonville, Florida 32207
(904) 737-3120

James Archer Smith Hospital
160 N.W. 13th STREET
HOMESTEAD, FLORIDA 33030
TEL: (305) 248-3232

OFFICE OF THE ADMINISTRATOR

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D. C. 20201

HOSPITAL = 100125

Dear Dr. Roper:

The opportunity to respond to the mortality data you provided of Medicare patients who died within 30 days of their last admission in 1986 is appreciated.

The enclosed summation and/or comments represent review by members of the Medical Staff of the cases listed as part of your communication of September 21, 1987.

Recommended for correction:

Patient ID [redacted] TR Severe Trauma to OR Orthopedic Disorders. Principal Diagnosis 820.8. Principal Procedure 81.62. This was a fracture of the hip with surgical repair.

Patient ID [redacted] TR Severe Trauma to OR Orthopedic Disorders. Principal Diagnosis 820.21. Principal Procedure 79.35. This was a fracture of the hip with surgical repair.

Patient ID [redacted] Principal Diagnosis 431. Patient was transferred to another facility (Baptist) on the same day as admission [redacted]; not a hospital mortality.

Patient ID [redacted] Last hospital admission was 8/7-8/10/86; not 7/24-7/25/86.

If the hospital can be of further assistance, please contact us. Your concern for the quality of patient care received by Medicare patients is appreciated.

Yours very truly,

Fernando Cardenas
Acting Administrator

C. Marshall House, M.D.
Chairman
Quality Assurance Committee

am

Your Good Neighbor In Quality Healthcare

James Archer Smith Hospital
160 N.W. 13th STREET
HOMESTEAD, FLORIDA 33030
TEL: (305) 248-3232

HOSPITAL = 100125

QUALITY ASSURANCE COMMITTEE
SUMMATION AND/OR COMMENTS BY MEMBERS OF THE MEDICAL STAFF OF JAMES ARCHER SMITH HOSPITAL FOR HCFA MORTALITY DATA RELEASE, 1987.

James Archer Smith Hospital is a 120-bed community acute-care facility. Most Medicare patients who expired were of advanced age; the average age was approximately 80. Most of the patients who expired were admitted with multiple medical problems, multi-system failure, and chronic long-standing conditions. In some cases, the patients were considered terminal and the patient and/or family did not wish heroic measures to be taken. Of the number of Medicare cases listed or 886 in all diagnostic categories, there were 74 mortalities.

With regard to the HCFA data submitted, the data as presented can be very misleading. The smaller the number of cases, the less reliable are the statistics. As the Federal Register notice stated, "The impact of random variation of outcomes in individual cases is greater". Any attempt to apply statistical analysis through a small number of cases and draw conclusions is fallacious.

HCFA data doesnot reflect severity of illness. The review by physicians revealed the care and treatment Medicare patients received was appropriate and reflected a high standard of care.

Diagnostic Category CA Cancer: Admissions cited were primarily terminal or pre-terminal. Patients were of advanced age (average 75). Most suffered from multi-system failure.

Diagnostic Category CE Cerebrovascular Accidents: Patients were of advanced age (average 78). The condition was severe in all cases. In one case, the patient was transferred to another facility on the same day as admission following a neurological consultation.

Diagnostic Category HM Severe Chronic Heart Disease: Patients were of advanced age (average 82). Most patients suffered from multiple medical problems as well as long-standing heart disease.

Diagnostic Category HS Severe Acute Heart Disease: Patients were of advanced age (average 77). In 4 of the 6 cases cited, patients suffered from acute myocardial infarction. Cardiac arrest and/or cardiogenic shock was experienced by 5 of the 6 cases cited.

Diagnostic Category ME Metabolic/Electrolyte Disturbances: Patients were of advanced age (average 80) and admitted with severe dehydration superimposed on severe underlying conditions. Physician reviewers felt that in two cases, the principal diagnosis should have been cancer and aspiration rather than the superimposed result or dehydration. One patient who was 82, terminally ill and died away from the hospital, was non-responsive to eating or drinking. Four of the five cases cited died away from the hospital. Although the conditions for prescribed hydration are monitored during a hospital stay, the hospital cannot control the fluid/food intake once the patient is discharged.

Diagnostic Category PN Pulmonary Disease: Patients were of advanced age (average 84) and suffered multi-medical problems as well as long-standing chronic conditions. In one case, in addition to the multi-medical problems, the patient suffered an acute myocardial infarction and heart failure. In another case, the presence of aspiration pneumonia had a grave impact.

Diagnostic Category RN Renal Disease: The two expirations of the total four admissions represented severely ill patients. Both had multi-medical problems. Both suffered from congestive heart failure and renal failure. In one case, it was difficult to determine whether the patient died of renal disease or one of other multiple disease processes. In the other case, the patient suffered from cancer and bronchial pneumonia.

Diagnostic Category SE Sepsis: The mortality rate for Sepsis at this facility was based on five cases admitted with the diagnosis of sepsis. Sepsis, which may result in the spread of a toxic-infectious condition, carries a high-mortality rate which in many cases is age related. The over 60-age group is the most susceptible. In addition to the severity of illness this condition presents, the four expirations represent patients with severe multi-system medical problems. Of the four expirations, three were terminal or pre-terminal.

Diagnostic Category TR Severe Trauma: The physician reviewers felt that the two cases cited should be classified as orthopedic since both were hip fractures with surgical repair. The actual mortality rate for Severe Trauma would then be

0% and for Orthopedic Disorders 9%. Patients were of advanced age (average 86). One patient had severe chronic lung disease, developed anoxemia, urinary shutdown and ventricular fibrillation. One patient had a history of cerebrovascular accidents and hypertensive cardiovascular disease. In the latter, the patient suffered myocardial infarction and went into cardiac arrest.

Diagnostic Category GI Gastrointestinal Disease: The one case cited of a 85-year old with cholecystitis had a cholecystectomy performed. The patient had chronic pancreatitis and a prior history of a cardiac condition. The patient suffered a massive coronary occlusion.

Diagnostic Category UN All Other Conditions: Patients were of advanced age (average 77). In most cases, patients suffered from multiple medical problems. More than half were terminal or pre-terminal. In some cases, the family did not wish heroic measures to be taken. One patient signed out against medical advice. Most suffered from long-term chronic conditions.



October 23, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Enclosed are the comments concerning the mortality data to be published by your department in December of 1987.

Thank you for the opportunity to comment on this data.

Sincerely,

Ned Stevens, M.D.
Vice President Medical Administration
JFK Medical Center
Medicare Provider Number 100080

P.O. BOX 1489 • LAKE WORTH, FLORIDA 33460 • (305) 965-7300

Results of Preliminary Medicare Record Review

The mean age of all deaths report was 78 years of age with a mean age in Metabolic/Electrolyte group being 80 years of age. 78% of all deaths were over the average life expectancy. 20.4% of deaths were after discharge from the hospital. 24.4% of deaths were inpatients with a diagnosis of a terminal illness.

In the Metabolic/Electrolyte Disorder deaths 29.7% of deaths were over 72 hours after discharge from the hospital. 51% of deaths were inpatients who had terminal illness.

Comments on Mortality Rates

The data does not take into account severity of illness or injury i.e., terminal illness or life threatening injury. Patients listed as dying in one category may have died of other causes than their primary DRG category. Since the data includes deaths which occurred after discharge, the hospital cannot verify that death was not due to other factors i.e., poor home or nursing home care, socioeconomic factors, other and/or new diseases, or even accidental death.

Many of the categories set up by HCFA have too few cases to be of any analytic significance. The data from which the figures were derived were not set up for this type of regression analysis. It was set up for Medicare billing purposes only. The data may create a false impression of care at any particular hospital. It has no relation to severity of illness, cause of death nor quality of care.

Comments on HCFA Mortality Study

JFK Medical Center, Atlantis, FL

Data Verification

Verification of data from HCFA, due to the fact that any one patient may have multiple admission and the high risk categories reported contain multiple DRG groupings, is not easily verified.

Interpretive Remarks

Below is an analysis of HCFA reported deaths. Table I relates to total number of deaths and Table II relates to the artificial category Metabolic/Electrolyte Disorders.

Table I	Patients	%
1. Total number of cases	3,401	
2. Total number of deaths	455	13% of cases
Analysis of Reported Deaths:	Patients	% of deaths
3. Mean age of all reported deaths	78 years of age	
4. Mean age of all ME reported deaths	80 years of age	
5. Total deaths in hospital	362	79.5%
6. Total deaths after discharge	93	20.4%
Number discharged to Nursing Home	50	11%
7. Number of patients diagnosed with terminal illness	111	24.4%
8. Number of patients older than the average life expectancy age:	358	78%
Number of female patients > 74 years of age		
Number of male patients > 70 years of age		

Table II

	Patients	%
1. Total number of cases	96	
2. Total number of deaths	37	38.5% of cases
Analysis of Deaths:		
3. Total number of deaths during Hospital admission	25	67.5% of deaths
4. Number of deaths within 72 hours of discharge	1	2.7% of deaths
5. Number of deaths > 72 hours after discharge	11	29.7% of deaths
6. Number of patients discharged to Nursing Home	11	29.7% of deaths
7. Number of patients diagnosed with terminal illness	19	51.0% of deaths
8. Number of female patients over 74 years of age	14	37.8% of deaths
9. Number of male patients over 70 years of age	17	45.9% of deaths

PALM BEACH
MARTIN COUNTY
MEDICAL CENTER INC

OFFICERS AND TRUSTEES
Richard W. Plowman
Chairman
George L. Ford, Jr., M.D.
President
William C. D'Arcy, Jr.
Vice Chairman
Dean D. Mergenthaler, M.D.
Vice President
Augustus G. Paine
Vice President
Wm. A. Kramer, 2nd
Secretary
Robert E. Grogan, M.D.
Treasurer
James D. Oenbrink, M.D.
Trustee
Wesley W. Oswald
Chief Executive Officer
T. Elbert Clemmons
Chairman Emeritus
James Kirkwood, Jr.
Chairman Emeritus
Stephen N. Martyak, M.D.
President Emeritus

BOARD OF ADVISORS
Fred E. Ahlbin
Clair G. Andersen
H. Brewster Atwater
Frederick W. Baldt
H. Lawrence Bogert
C.L. Brumback, M.D.
Bert S. Cross
Mrs. Loretta-Anne D'Arcy
C. Douglas Dillon
Ronald C. Dudan, M.D.
Edwin D. Etherington
Tscheng S. Feng, M.D.
Thomas M. Gocke, M.D.
Mrs. Elizabeth Hayes
Frank L. Henderson
Vernon A. Johnson
J. Peter Lawler, M.D.
Francis B. Maraist, M.D.
M.E. Mayo
Joseph H. McChristian
Richard B. Moore, M.D.
Buel Morley, M.D.
Thomas C. Murray
Kenneth S. Reames
Mrs. Joseph V. Reed
Daniel C. Searle
William J. Taylor
Robert C. Tyo
Charles R. L. White
Bruce E. Wilita, M.D.
Robert S. Young, Jr., M.D.

October 22, 1987

William L. Roper, M.D.
The Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

HCFA Mortality Rates

Following is our response to the HCFA Mortality Report dated September 21, 1987.

Your report shows that there were 1,594 admissions of Medicare patients for 1986. Our records show there were 2,449 admissions of Medicare patients. We believe this discrepancy is the result of your report counting each Medicare beneficiary only once, even if they were admitted several times. Your report shows that 123 Medicare patients died during hospitalization and 32 died within 30 days following discharge. Our records show that 123 patients died during hospitalization and 33 post discharge.

While Jupiter Hospital falls well within the ranges published in your report, we want to record our belief that the HCFA data and the "predicted mortality rate" for each facility is in no way a reliable judgment of the quality of care. There are a wide range of factors with a significant impact on mortality that are not included in the HCFA data, including the general health status and the stage of the patients illness. It is interesting to note that 15 of the 33 post hospital deaths included in our mortality data were discharged to nursing homes. The diagnostic categories GI and PN, for example, total 315 cases. Of those 35 patients expired within 30 days of admission to Jupiter Hospital. Almost half of those 35 patients had histories of severe heart disease or malignancies.

Judgment as to the quality of care received can only be made after a thorough review of the patients medical record. HCFA does not reflect the "actual cause of death" in it's analysis, but the principal diagnosis identified by the attending physician for the patients last admission. It is important to note that patients with significant chronic degenerative or terminal conditions may significantly alter the reported mortality rate.

Sincerely,

Thomas C. Jolly
Chief Operating Officer

Post Office Drawer 997, Jupiter, Florida 33468-0997 • (305) 747-2020

Denny W. Powell
President

Kissimmee Memorial Hospital

Another
Basic
American
Medical
Company

October 15, 1987

William L. Roper, Administrator
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Roper,

This letter is to serve as a response to the mortality data for our hospital that you have prepared and submitted to us for review and verification. We have examined the data carefully and wish to make the following comments:

1. Your data shows that 912 Medicare patients were admitted to our hospital in 1986. In fact, our hospital had 1,601 Medicare admissions last year - a difference of 609 patients. A low percentage of this difference may be attributed to repeat admissions per patient, however, your letter did not indicate the method in which the 912 admissions were derived.

2. The patient detail you submitted included 15 patients who died after discharge. Our data shows that two of those patients actually died while in the hospital. Of the 13 remaining patients, we feel that it is impossible and unfair to attempt to relate the cause of death,occurring as many as 25 days after discharge in one case, to the reason the patient was hospitalized. Other acute and/or chronic illnesses could have caused the death, as could have severe accidents or traumatic injuries.

3. All in-house deaths that you have listed for our hospital are correct; however, our data shows an additional 13 in-house deaths in 1986.

4. As a result of the inaccurate data as discussed above, your overall mortality rate for our hospital is overstated at 11%. Using the accurate figure of 1,601 Medicare admissions, and adding 13 additional deaths to the 100 you have listed, we

200 Hilda Street
Box 2108
Kissimmee, Florida 32742-2108
(305) 846-4343

calculate a valid mortality rate of 7%. Your data for individual diagnostic categories would therefore be inaccurate as well. Given the time constraints for our response to be submitted, it is impossible to research the 609 admissions you do not have, assign them to diagnostic categories, and calculate mortality rates for each.

These points summarize the major concerns that Kissimmee Memorial Hospital has identified from the mortality data you have prepared regarding our facility. In compliance with your request, we have not included any individual patient data in our comments. We would be happy to do so at a later date in order to substantiate the errors in your data for our hospital.

Sincerely,

Denny W. Powell

Denny W. Powell
President, Kissimmee Memorial Hospital
Provider # 10-0089

cc: Mike Rust, Florida Hospital Association

LAKE SHORE HOSPITAL, INC.
A SANTAFE HEALTHCARE CENTER

October 27, 1987

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Lake Shore Hospital, Incorporated, has reviewed the Medicare mortality information published by the Health Care Financing Administration and we found no significant errors in the data. We were pleased to see that in all of the mortality rates for our hospital we were well within the range set by the Health Care Financing Administration. Lake Shore Hospital is committed to a high standard of quality health care and we realize that we must monitor continually the assessment of this quality. This study involves only one variable of the total quality of care indicators which may change dramatically over the course of time and may not be a true indicator of quality health care.

Lake Shore Hospital, Incorporated, is a 128-bed, not-for-profit community hospital providing a wide range of services to the citizens of Lake City, Columbia County and the surrounding area. The hospital's range of services includes, but is not limited to; medical, surgical, pediatric, obstetric and gynecology, intensive/cardiac care unit, and the only emergency department to serve Columbia County. Our medical staff is comprised of physicians covering many specialties and sub-specialties. Since we provide the only emergency department in the area, and due to our geographical location at the intersection of two interstate highways, we receive and treat a large number of patients with varied medical problems. Given the complexity of the patients who are seen at the hospital, we are very pleased that our mortality data shows us to be well within the ranges established by the Health Care Financing Administration.

Lake Shore Hospital has in place a comprehensive quality assurance monitoring program which is accredited by the Joint Commission on Accreditation of Health Care. This quality assurance program monitors all patients who are seen and treated in the hospital and includes a review of every death occurring within the hospital. The Medical Staff physicians participate in this ongoing review of quality indicators that are part of the overall quality assurance program

to insure that the highest quality care is delivered to the patients who utilize our services. We believe that the comprehensive program that we have is a better indicator of quality of care than one variable which by its very nature is susceptable to wide fluctuaitions over time. Lake Shore Hospital, Incorporated, is committed to providing a high standard of quality health care which is monitored through our ongoing quality assurance program.

Sincerely,

Jeffrey M. Judd

Jeffrey M. Judd
Administrator

lj

Lakeland Regional Medical Center

1324 Lakeland Hills Boulevard • P.O. Box 95448 • Lakeland, Florida 33804 • (813) 687-1100

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
6300 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for providing our institution the opportunity to review and comment upon the selected mortality information for Medicare patients in 1986 which will be published by HCFA for all hospitals in December, 1987.

The data provided by HCFA indicate that 658 Medicare patients admitted to LRMC died within 30 days of admission. Review of our own records verifies the HCFA data as presented.

The hospital is pleased to note that the actual mortality rate for all causes, and for all sixteen categories of death, fall within the range of predicted mortality rates developed by the HCFA model. Since the HCFA data includes deaths which occurred within 30 days of the patient's last admission, it is appropriate to point out that 142 or 21.5% of the deaths occurred after the patient was discharged from the hospital. The public should be aware that some of these patients died from causes unrelated to their last hospital admission.

As you point out in your cover letter, the HCFA "information on its own is not a complete measure of the quality of care at an individual hospital." Since the HCFA model attempts to predict mortality rates for an "average" hospital, hospitals such as LRMC, which serves as a high technology, tertiary, referral institution in a single provider community with a high percentage of severely ill and elderly patient admissions, would tend to be inappropriately compared to institutions admitting patients with a lesser severity of illness.

The above notwithstanding, the hospital welcomes the opportunity to use the HCFA data as one additional element in our comprehensive quality review process. As you are well aware, mortality statistics are but one measure among many in the hospital's efforts to assure quality care to its patients. Through our medical staff's peer review process, all deaths are continuously reviewed on a monthly basis along with numerous other quality measures. This in-depth analysis of individual deaths provides a basis upon which quality issues may be identified and appropriate action taken. Although

simplistic statistical comparisons may be appropriately used to focus or guide peer review, it is by no means a proper substitute, and those in our community should not be led to conclude that the HCFA statistics may be used to measure quality. The value of the data lie in their use as a tool to help ensure the effectiveness of our quality assurance program.

Sincerely,

Jack T. Stephens
President/CEO

JTS/ls

HCA Largo Medical Center Hospital

October 27, 1987

Mr. Harvey Brook
Health Standards & Quality Bureau
Health Care Financing Administration
Rm. 2-D-2 Meadows East Bldg.
6300 Security Blvd.
Baltimore, MD 21207

Dear Mr. Brook:

Please find attached HCA Largo Medical Center Hospital's comments to the HCFA Mortality Data. If you should have any questions regarding this response, please feel free to contact me.

Sincerely,

Winston Rushing
Administrator

201 Fourteenth Street S.W.
P.O. Box 2905
Largo, Florida 34649-2905
Telephone (813) 586-1411
A Subsidiary of HCA The Healthcare Company

HCA Largo Medical Center Hospital

COMMENTS ON HCFA MORTALITY DATA

HCA LARGO MEDICAL CENTER HOSPITAL

LARGO, FLORIDA

PROVIDER # 10-0248

The data used by HCFA indicate that in 1986 a total of 348 Medicare patients admitted to HCA Largo Medical Center Hospital died within 30 days of admission. Of these, 299 died while still a patient of the hospital, while 48 died after discharge. Our own records indicate that in 1986, 5475 Medicare admissions occurred at HCA Largo Medical Center Hospital. The actual numbers compiled by HCFA for this hospital are correct. However, it is essential to realize that mortality data are not, in themselves, measures of hospital performance. Reports, such as the HCFA Mortality Data, need to be seen in their proper context in order to accurately interpret them and to identify their potential use.

The HCFA Mortality Statistics were developed by tallying the number of Medicare deaths that occurred within 30 days of admission to the hospital. Since this hospital treats patients with other types of insurance or no insurance coverage, the statistics presented by HCFA are incomplete. In addition, the statistics are misleading since approximately 14% of the deaths included in the HCFA data occurred after the patient was discharged from the hospital. Review of the medical records for those patients indicates that the prognosis for many of them was guarded. However, there was no follow up on these patients' deaths to determine that the cause of death was actually related to the diagnosis that required the hospitalization. The HCFA report fails to determine if some of these people died from injuries or illnesses unrelated to reasons for the previous hospital stay. On the other hand, HCFA did not include the deaths of Medicare patients who were hospitalized more than 30 days prior to dying. Based on these factors, one must realize that the HCFA mortality report does not accurately and completely reflect the overall mortality rate for the Hospital.

In addition to being incomplete, a serious risk of misinterpretation of the HCFA data exists because each death was categorized from information on the Medicare billing statement. This statement lists the specific medical diagnosis that prompted the patient's hospitalization and does not list the actual cause of death, which may or may not have been related to the admitting diagnosis. For instance, most patients grouped in the category of admission for low risk heart disease actually deteriorated and died of illnesses such as, acute myocardial infarction, ruptured aortic aneurysm, or pulmonary edema, all of which fall into the high risk heart disease category.

201 Fourteenth Street S.W.
P.O. Box 2905
Largo, Florida 34649-2905
Telephone (813) 586-1411
A Subsidiary of HCA The Healthcare Company

Another factor that was not reflected in the data is the co-existence of other conditions that may have contributed to death. Review of the medical records indicated that in every category and in many of the cases, patients had other serious conditions that in conjunction with the primary disease contributed to the demise of the patient. For example, patients grouped into the diagnostic categories of metabolic/electrolyte disturbance or orthopedic disorders frequently had co-morbid conditions, such as cancer, congestive heart failure or kidney failure.

A factor not made clear by the HCFA report relates to age. Of the 348 deaths that occurred following admission to HCA Largo Medical Center Hospital, 118 occurred in people age 80 or older.

It should be noted that the HCFA model for estimating expected mortality included only a few variable factors. The HCFA system did not account for severity of illness or duration or stage of the disease process, all of which are very important in predicting outcome for any given patient. In reviewing the complete medical records of the patients who died from cancer, it is noticeable that many had metastatic cancer and diagnosis was made and treatment begun at various stages of the disease process. Also, cancer is a broad term that includes hundreds of specific diagnoses and each specific type of cancer carries its own prognosis or expected outcome. The rate of survival from any cancer almost always relates to the time in the disease process that the cancer was discovered and therapy initiated.

Lastly, consideration must be given to the unique services and patient population of this Hospital that contribute to higher than average mortality. HCA Largo Medical Center Hospital is a referral center for sophisticated cardiac diagnostic procedures and open heart surgery. Several hospitals and physicians throughout a two county area refer their unstable cardiac patients for specialized evaluation and therapy. This factor of specialization and therefore attraction of critically ill patients was not included in HCFA's statistical model for predicting mortality for this or any hospital and, it is logical that specialization for high risk areas would affect the probability of death.

In conclusion, the applications of the HCFA mortality figures are extremely limited and do not in any way reflect quality of care provided in any hospital. While assessment of quality of care is of vital importance to patients and healthcare providers alike, quality of care cannot be measured by an accumulation of numbers, but by a concurrent and retrospective review of clinical practice by physicians and other healthcare professionals. Doctors, hospitals and care givers are committed to providing excellent care to all patients and welcome valid methods to measure quality. The HCFA statistics do not assist in that measurement.

LARKIN GENERAL HOSPITAL
7031 Southwest 62 Avenue, P.O. Box 43-1810, South Miami, Florida 33243 (305) 666-6500

October 23, 1987

Health Care Financing Administration,
Health Standards and Quality Bureau
Hospital Mortality Information
P.O.Box 26684
Baltimore, Maryland 21207

RE: Larkin General Hospital - South Miami
Medicare Provider # 10-0181

Following are our comments for release with your mortality date for our hospital.

Our first inclination was not to comment on the mortality data. We were at the low end of the "range of predicted mortality rates," i.e., 6% (of 6 to 15%).

Review, however, disclosed that seven of the twenty-three deaths attributed to our hospital occurred elsewhere; consequently, the mortality rate was 4%. If the standard and recognized formula were used - the ratio of mortalities to the number of Medicare admissions - the rate would be much lower. HCFA has computed the mortalities by the ratio of deaths to the number of Medicare patients regardless of the number of admissions.

All but two deaths were in HCFA's high risk category and these two did not occur in our hospital.

HCFA's statement, "that the information on its own is not a complete measure of the quality of care at an individual hospital." is certainly an understatment.

Please communicate with me if you have any questions.

E. Tim Cook,
Administrator

ETC:yh

MEDICAL STAFF
LEE MEMORIAL HOSPITAL

P. O. Box 2231
Fort Myers, FL 33902
813/334-5999

October 26, 1987

Health Care Financing Administration
Department Health and Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20036

Gentlemen:

We appreciate the opportunity to review our Medicare Mortality Data prior to the general release.

All of this information has been carefully evaluated and combined with our regular assessment of quality. The task was made more difficult by the fact that most studies, including the PRO, use DRG mortality while HCFA utilizes diagnostic categories based on ICD-9CM codes. If the data was comparable, the reviews could have been done more efficiently and complimented our ongoing program.

Lee Memorial Hospital was pleased that the mortality data fell within the ranges that were expected. To further exemplify the importance we place on this, the Quality Assurance Committee knows that mortality review is an important component of peer review. 100% of all deaths are reviewed in this hospital.

Respectfully,

Robert E. Arnall MD

Robert E. Arnall
Medical Director

REA:ams

COMMENTS ON THE HCFA

MORTALITY DATA

Lykes Memorial Hospital

Brooksville, Florida

Medicare Provider Number: 10-0071

The data used by HCFA indicate that for the year in questio. the actual mortality rate at Lykes Memorial Hospital was within the range of predicted mortality rates. Our records indicate a difference between the number of Medicare admissions we reflect and the number reported in the mortality data. Presumably the discrepancy reflects multiple admissions of individual beneficiaries or other reporting differences. We have no way to reconcile the total number of Medicare patients per the mortality report to our own records.

Although the data are favorable to Lykes Memorial Hospital in that the mortality rates are within the predicted ranges for the data reported, there are several reasons why the actual mortality rates might exceed the ranges:

1. The data do not take into account the severity of the individual patient's injury or illness. Patients in critical condition or who are terminally ill are included in the data. When admitted to the hospital, the patient may be barely alive. Death is the expected result of many admissions.

2. Patients may have more than one medical problem. Some patients do not die from the principal diagnosis. For example, patients admitted under the pneumonia DRG have died from cancer, heart attacks and strokes, but the data show them in the pneumonia DRG. Mortality data only show why a patient was admitted, not why the patient died.

3. The data include patients who die within 30 days after hospital admission, whether or not the patient is in the hospital at the time of death. In the 30 days hospitals have to review and comment on the data, it is difficult to verify the circumstances of out-of-hospital deaths. A death may result from poor care outside the hospital.

4. In addition to the severity of illness, other factors contributing to the probability of death, also not taken into account by HFCA, are the patient's general

health status, stage of illness, psychological condition, and degree of family support.

5. The age of the patient is another factor. Many deaths are of individuals in their 80s and 90s who may be less likely to survive serious illness or injury.

6. The data do not show where the patients come from. Patients admitted through the emergency department, a high source of admissions at Lykes Memorial Hospital, are generally more high-risk candidates for surgery or treatment than others, and patients admitted from nursing homes, another significant source of admission at Lykes Memorial Hospital, tend to be sicker than those admitted who are still able to care for themselves at home.

7. The data may be misleading if there are only a small number of patients in a particular category. The smaller the number, the more likely the number is subject to misinterpretation. A particular death rate may be the result of chance, rather than medical care.

Lykes Memorial Hospital is proud of the standard of quality represented in the care delivered to its patients. We are committed to being responsive to the needs of the population we serve. The mortality data reported by HCFA, although favorable to Lykes Memorial Hospital, are not a measure of quality and should be used only with care.

Sincerely,

David H. McReynolds
Executive Director

MEDICAL CENTER HOSPITAL

A Community Hospital
Owned & Operated by the
Seventh-day Adventist Church

809 East Marion Avenue • Punta Gorda, Florida 33950-3898
Mailing Address: P.O. Box 1309 • Punta Gorda, Florida 33951-1309
Phone (813) 639-3131

October 15, 1987

Health Care Financing & Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Response to Mortality Rate Information for
Medical Center Hospital ID# 100047
Punta Gorda, Florida

Dear Sir/Madam:

Thank you very much for the opportunity to review the mortality information prior to release to the press. Reviewing this information is very beneficial to the hospital staff and it has given us an opportunity to once again review a concise form the deaths of patients and previous patients of Medical Center Hospital.

A review of this statistical information does not indicate any area of special concern. The only two mortality rates that draw any attention are HM-Severe Chronic Heart Disease and HS-Severe Acute Heart Disease, where the rates are 25 percent and 41 percent respectively. Even though neither of these exceed the range of predicted mortality rates, they are a bit higher in the range than most of the other rates for this hospital. The explanation for those increases would be as follows:

> Medical Center Hospital functions as a cardiac center for Charlotte County, being the only facility in this county to be granted a Certificate of Need for heart catheterization studies. To support the high level of cardiac care, this institution has a cardiac intensive care unit, an array of monitored beds and complete cardiac support services up to, but not including angioplasty or open heart surgery. During the year of 1986 we also offered the services of the only intraortic cardiac balloon pump in the area. Because of these available services, this hospital has served as the cardiac center for this area and has consistently received patient transfers from other area hospitals for heart catheterizations and/or intraortic balloon pump

- more

support. It is only natural to conclude that because the other hospitals in the area do have moderate support services, that the cases transferred to our facility are among those needing the highest degree of care or those with the highest severity index. Although we do not have access to the numbers in the other hospitals, I would venture to say that our patient population is made up of a disproportionate share of patients in these two categories, as compared with other area hospitals.

Thank you very much for this opportunity to comment on the mortality rates prior to publication.

ValGene Devitt
President

VGD:rc

Memorial Hospital

(305) 987-2000

October 20, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Responding to your request to review the mortality information for Medicare patients treated at Memorial hospital during the year 1986, a listing of errors of 6 patients is noted below:

LISTING OF ERRORS

HIC #	AGE	ERROR
[redacted]	74	Not a patient at Memorial Hospital
	89	Date of expiration incorrect
	83	Date of expiration incorrect
	80	Date of expiration incorrect
	82	Date of expiration incorrect
	78	Date of discharge incorrect

As a community leader in providing quality health care to its residents, regardless of their ability to pay, Memorial Hospital services 115,379 patients annually. We recognize the difficulties in accurately presenting large volumes of data.

The recent HCFA data accompanied by predicted mortality rates is an improvement over past data publications. However, careful assessment and extensive dialogue with hospital representatives is critical prior to media or consumer use of this information.

Memorial Hospital is a 737 bed acute care hospital, distinguished as a provider of care for cancer patients, heart surgery and neurosurgical patients, and trauma victims.

Memorial accepts a large number of transfers from facilities that do not provide such services to critically ill or injured patients. Approximately 5% of the Medicare mortalities at Memorial Hospital were transferred to us from other hospitals, and were in most instances patients with advanced disease, multiple medical problems, or multiple trauma. Disappointing in the HCFA data is its inability to adjust for these cases. The severity of illness or injury for each patient is a basic factor in the evaluation of the data. Thus we consider the patient medical record to be the most valuable tool in evaluating mortality of all patients of Memorial Hospital.

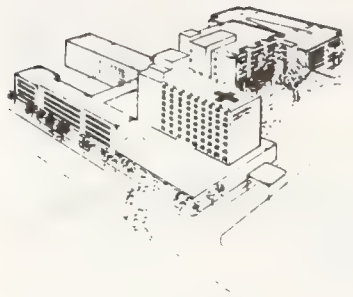
This evaluation of all hospital mortalities is an integral part of our extensive ongoing patient quality management program, which not only vigorously assesses the question of "was death imminent," but evaluates the quality of patient care in every area and every service of our hospital for every patient; and we care for those with terminal illnesses, just as we care for those who are temporarily incapacitated.

Memorial Hospital supports the presentation of meaningful accurate outcome data, provided there is clear knowledge and understanding that such data must be evaluated only in conjunction with a full assessment of each patient's clinical condition, coexisting illnesses, and a complete review of the medical record - a process which we incorporate into our vigorous and ongoing quality assurance practice and peer review.

Sincerely,

Frank V. Sacco, Administrator
Memorial Hospital

FVS:bl



SARASOTA MEMORIAL HOSPITAL
Center of Care

Philip K. Beauchamp, F.A.C.H.E., President

October 29, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Reference: Hospital Mortality Information
Medicare Provider Number 100087

Dear Sir:

On September 24, 1987, Sarasota Memorial Hospital received a packet of statistics purported to display the number of Medicare patients admitted to our hospital during 1986, the actual percentage of those patients who died in house as well as those dying within 30 days of their last 1986 admission, and a predicted range of the percent of patients who would have been expected to die. We were invited to comment by October 30, 1987. Please consider this letter as our response.

The cover letter also stated that this information had been developed using "sophisticated statistical techniques based upon the advice of experts". Unfortunately the precise analytic methodology and data validation techniques were not included.

Furthermore, the hospital was unable to validate the expected mortality range or its position within the range with the data provided due to the complexity of the statistical analysis. As the HCFA data was generated from billing sources, correlation to quality of medical care is not a logically supported conclusion. Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the analysis. Since data was generated on the reason for admission and not the reason for death, this limits the hospital's ability to document and interpret the significance of the findings.

Although all of the hospital's mortality rates lie within the expected ranges and serve as evidence of the standards of care practiced at Sarasota Memorial, the hospital has concerns whether death review statistics are a valid measure of the quality of care. Death data which does not include a measure of the severity of illness, the patient's general health status, stage of illness, age, lifestyle, prehospital treatment, financial situation, home environment, and psychological condition reveals little about hospital performance. Inclusion of these factors on the overall evaluation are necessary to avoid misleading conclusions.

Sarasota Memorial Hospital has its own monitors of the quality and appropriateness of care which include a review of deaths independent of payor source or risk classification. A careful chart by chart systematic approach to the identification of potential problems has been in effect for several years. Where available and appropriate comparisons to state and national mortality statistics for particular procedures and/or conditions are part of the total analysis.

We feel that publishing such data at a time when hospitals are trying to effect life saving practices is counterproductive. Interpretations of quality must extend beyond a single statistic to become meaningful.

Patients treated at Sarasota Memorial Hospital are more seriously ill than those found at other local hospitals. The hospital's reputation as one of the leading health care providers in Florida attracts the transfer of high risk patients who require sophisticated equipment and the services of our highly qualified, experienced medical staff. As a tertiary facility many patients are admitted in the final stages of illness. Logically, these factors will tend to elevate the percentage of deaths.

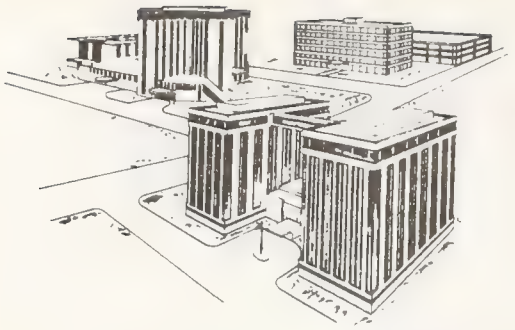
More importantly, however, is the implied value of the data. Results concerning Sarasota Memorial show that we are saving a greater number of people than other hospitals. Death rates demonstrate the safety and effectiveness of care provided by our medical staff and other health care providers. The course of an illness is affected by a variety of circumstances. Death occurs from a combination of disease and treatment factors, therefore, the low overall death rate in a population at such high risk is but one indicator that the hospital's internal monitors for standards of care are effective.

Sincerely,

Philip K. Beauchamp, President

R. W. Hoefer, M.D.

R. W. Hoefer, M.D., Chief of Staff



METHODIST HOSPITAL

METHODIST HOSPITAL FOUNDATION

MEDICAL CENTER PLAZA

580 WEST EIGHTH STREET • JACKSONVILLE, FLORIDA 32209

TELEPHONE (904) 798-8000

MARCUS E. DREWA, F.A.C.H.E.
President

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health &
Human Services
Health Care Financing
Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Re: Hospital Number #100170

Dear Mr. Roper:

Methodist Hospital, a 244 bed not-for-profit, non-denominational, acute care community hospital provides a comprehensive range of medical/surgical, diabetic treatment and hospice services. Methodist Hospital is fully accreditated by the Joint Commission on Accreditation of Healthcare Organizations and the Florida Department of Health and Rehabilitative Services. In addition, the Hospital is a member of the Voluntary Hospitals of America, the American Hospital Association, the Florida Hospital Association, the Jacksonville Hospital Council and the Jacksonville Health Education Program.

The following comments are made in response to HCFA concerning the mortality data received by Methodist Hospital:

1. Methodist Hospital has no record of the following patients being admitted:

   a. [redacted] 4/11/86 to 4/16/86, with date of death 4/30/86.

   b. [redacted] 12/18/86 to 12/25/86 with date of death 1/16/87.

2. Reviewing the total number of deaths reported by HCFA, seven (7) percent were attributed to the Hospice Program and thirteen (13) percent did not expire in the hospital for a sum of twenty (20) percent of the total reported deaths. (See attached Table #1).

3. Revised actual mortality rates excluding Hospice and those that did not expire in the Hospital are as follows: (See attached Table #2)

Reviewing this table demonstrates that if we exclude those deaths occuring in Hospice (1% of total mortality rate) and outside the Hospital (2% of total mortality rate) that all diagnostic categories fall within the expected mortality ranges. This brings our actual mortality rate down to 10% causing it to fall in the lower end of the predicted rate.

The Department of Health and Human Services states that the mortality information on its own is not a complete measure of the quality of care at an individual hospital. HCFA further states that: "We cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals".

Methodist Hospital has had a comprehensive Hospice Program since June, 1980. Methodist Hospital was the leader in the State of Florida pioneering the state's first Hospice inpatient facility which is still the only such unit for expected terminal patients in Northeast Florida. Methodist Hospital Hospice is a program of palliative service that provides physical, pyschological, social and spiritual care for dying persons and their families. Palliative care is treatment designed to relieve symptoms such as pain and nausea without curing the disease. Palliative care treats the patient and family, not the disease. Hospice care begins where conventional medical treatment leaves off so that the medical community no longer has to say "There is nothing more that we can do". The Hospice philosophy is to affirm life; to live life as fully and as comfortably as possible and to recognize death as a normal process. Increased utilization of Methodist Hospital services by Medicare patients, nursing home bed shortages in Jacksonville, along with an increase in the severity of illness, and the utilization of a Hospice Program treating known terminal patients, all must be considered when looking at mortality data.

Methodist Hospital recieved its three year accreditation from the Joint Commission on Accreditation of Hospitals on March 19, 1987. The Hospital received this accreditation following a comprehensive survey of its Quality Assurance Program. Methodist Hospital's Quality Assurance Program

encompasses departmental review of all patients receiving services at the Hospital. Those standards of care that are not met are reviewed by and action taken at the appropriate medical department with communication being made to the Quality Assurance Committee, Medical Executive Committee and the Board of Trustees.

Any further information regarding the Mortality Information should be addressed to Mr. Randy Gray, Director of Public Relations, Methodist Hospital, Telephone #(904) 798-8291.

Sincerely,

Marcus E. Drewa
President
Methodist Hospital

MED:vlz

cc: Mr. Ed Jordan
Mr. Kevin Cuda

METHODIST HOSPITAL

1986 HCFA MORTALITY STUDY

TABLE #1

DIAGNOSTIC CATEGORY	TOTAL CASES	EXPIRED IN HOSPICE	DID NOT EXPIRE IN HOSPITAL	NO RECORD
CA	28	7	6	0
CE	22	5	0	0
EY	0	0	0	0
GC	4	0	0	0
GI	14	0	1	0
GU	6	0	1	0
GY	0	0	0	0
HL	9	1	3	0
HM	24	1	4	0
HS	18	0	1	0
ME	27	1	3	0
OP	2	0	0	0
PN	48	1	5	0
RN	8	1	2	0
SE	10	0	1	0
TR	3	0	0	0
UN	61	3	8	2
TOTALS:	284	20	35	2

METHODIST HOSPITAL

1986 HCFA MORTALITY STUDY

TABLE #2

	All Cases	HCFA Mortality Rate	Exclude Hospice	Exclude Hospice deaths ≠ Outside Hospital	Range Predicted Mortality Rates
ALL CAUSES	2201	13%	12%	10%	9 - 15%
CA - CANCER	132	21%	16%	11%	14 - 32%
CE - CEREBROVASCULAR ACCIDENTS	99	22%	17%	17%	18 - 37%
EY - OPHTHALMOLOGIC DISEASE	6	0%	0%	0%	0 - 100%
GC - GASTROINTESTINAL CATASTROPHES	34	12%	12%	12%	7 - 34%
GI - GASTROINTESTINAL DISEASE	263	5%	5%	5%	3 - 9%
GU - UROLOGIC DISEASE	101	6%	6%	6%	2 - 14%
GY - GYNECOLOGIC DISEASE	14	0%	0%	0%	0 - 96%
HL - LOW RISK HEART DISEASE	127	7%	6%	4%	2 - 11%
HM - SEVERE CHRONIC HEART DISEASE	135	18%	17%	14%	15 - 30%
HS - SEVERE ACTUE HEART DISEASE	54	33%	33%	31%	24 - 51%
ME - METABOLIC/ELECTROLYTE DISTURBANCES	116	23%	22%	20%	10 - 29%
OP - ORTHOPEDIC DISORDERS	71	3%	3%	3%	0 - 10%
PN - PULMONARY DISEASE	178	27%	26%	24%	12 - 26%
RN - RENAL DISEASE	27	30%	26%	19%	7 - 45%
SE - SEPSIS	26	38%	38%	35%	18 - 55%
TR - SEVERE TRAUMA	46	7%	7%	7%	3 - 22%
UNKNOWN	61	#3	#8		

FL 162.4

METROPOLITAN GENERAL HOSPITAL INC.
AN OSTEOPATHIC INSTITUTION

MEDICARE PROVIDER NUMBER 100145

October 26, 1987

William L. Roper M.D.
Administrator
Health Care Finance Administration
Washington, D.C. 20201

Dr. Mr. Roper:

In regards to the mortality information submitted to our hospital for review, the following discrepancies were found.

For "All causes" the total cases listed is 1,140. However, when you add up the breakdown of the sixteen diagnostic categories the cases total 813. Thus, a difference of 327 cases.

The totals you have listed for our facility are inaccurate. For 1986, Metropolitan General Hospital had a total of 1,836 medicare admissions. The total medicare deaths was 125. An actual mortality rate of 6.8%.

You have listed an additional 27 patients who died elsewhere and do not have any bearing on the mortality statistics of Metropolitan General Hospital.

Thus the information you have submitted based on your calculations is not accurate, and should be corrected so that publication of inaccurate data does not occur.

Sincerely,

Jeanna Burchick

Jeanna Burchick, RRA
Director, Medical Records

7950 - 66th Street North, Post Office Box 30
Pinellas Park, Florida 33565 Telephone 813/546-9871

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Morton Plant Hospital

323 Jeffords Street • P.O. Box 210 • Clearwater, Florida 34617 • (813) 462-7000

MEDICARE PROVIDER NO: 100127

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for your letter of September 21 requesting comments on the mortality data. We appreciate your publishing our views.

About six out of every ten patients treated at Morton Plant Hospital are age 65 or older; yet data published by the Health Care Financing Administration (HCFA) on mortality rates nationwide appear to cast Morton Plant in a favorable light with regard to quality of care.

Nevertheless, Morton Plant Hospital supports the position of the American Hospital Association (AHA) that the HCFA data are flawed and in no way useful in helping individuals to compare or evaluate the performance of physicians or hospitals.

It is clear, for example, that the HCFA death rates used to compare hospital mortality statistics cannot take into consideration the severity of the illness which was the cause of death in individual cases because, as AHA Executive, Jack W. Owen, has pointed out, "for now--and for the near future--no comprehensive measure of severity of illness exists."

Morton Plant Hospital, however, fully endorses and supports the following statement made about the mortality data by the Administrator of HCFA:

> "We cannot and do not recommend the use of the information by itself to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals."

Sincerely,

Robert L. Graves

Robert L. Graves
Executive Vice President/
Chief Operating Officer

RLG:mbh

Mount Sinai
MEDICAL CENTER
OF GREATER MIAMI

October 21, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Baltimore, MD 21207

Dear Doctor Roper:

Medicare No. 100034

Mount Sinai Medical Center supports the absolute right of the public to know the quality of medical care rendered at Mount Sinai and other hospitals. We are concerned, however, that incomplete and misleading information contained in the HCFA mortality data disclosure can do grave harm.

In your September 21, 1987 letter to hospital administrators, you stated concern regarding the possible misuse of the mortality data: "In the public release of information, HCFA will make clear that the information on its own is not a complete measure of the quality of care at an individual hospital. While we believe that information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we can not and do not recommend the use of the information by itself to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals."

Since HCFA has elected t_ release mortality profiles in spite of your reservations, the following issues must be considered when reviewing the data:

1. The methodology for compiling the data is not valid. The methodology attributing a patient's death to the principal diagnosis is erroneous. The principal diagnosis is defined by HCFA as the reason for hospital admission and is the basis for diagnostic grouping. A patient may be admitted for orthopaedic surgery, suffer an acute myocardial infarction, and expire and the case would be noted as an orthopaedic mortality. The methodology used in determining designation of categories is misleading. For example, HCFA's diagnostic category "Low Risk Heart Disease" contains conditions often requiring coronary

4300 Alton Road • Miami Beach, Florida 33140 • Telephone (305) 674-2121

bypass surgery or heart valve replacement. Both surgeries are complex, particularly in high risk patients. The designation gives the impression that patients died from a "low risk" condition.

Regardless of the actual cause of death, a patient who dies within thirty days after the date of admission is included in the statistics. For example, a patient who is discharged following prostate surgery and expires for any reason (heart attack, suicide, automobile accident, etc.) is considered a urologic mortality, whereas the death was totally unrelated to the prior hospitalization. If a patient had more than one hospitalization, only the last hospitalization is included, thus unfairly increasing death rates for hospitals treating terminally ill patients. Patients with end-stage heart disease or advanced cancer can be expected to have multiple admissions as their condition worsens. Yet, only the last admission, which often results in death, is included in the data.

2. The data does not show how the patient came to the hospital. Mortality rates differ significantly depending on the patient's mode of entry to the hospital. Patients admitted from nursing homes have more severe medical problems when compared to patients who care for themselves at home. Patients admitted through an emergency or trauma unit are more severely ill than patients admitted electively. Mount Sinai's mortality profile includes an 87-year-old patient brought to the Emergency Room, suffering a massive subdural hematoma from an accident; the patient was near death when admitted.

3. The data does not take into account the patient's severity of iilness or socioeconomic background. For statistics of the type presented in these profiles to be meaningful, patient mix at each institution must be known. Patients who are terminally ill or in critical condition from accidents and have no chance to survive are included in the data. Medically indigent patients may not seek early medical care and often aren't admitted to a hospital until they have a serious medical problem.

4. The data does not compare the relative activities, capabilities, and size and complexity of institutions in the study. All hospitals are not equal. Mount Sinai is a teaching hospital offering sophisticated medical services; we are a referral center for the seriously ill patient who has complicated medical problems. One patient appearing in the profile had metastatic carcinoma and was initially diagnosed and treated at another area institution. The patient was subsequently admitted to Mount Sinai in a final effort to provide more specialized care.

Mount Sinai Medical Center has an active emergency service and, as a Trauma Center, received and treated the majority of the critically ill and injured patients on Miami Beach. One patient in the profile suffered severe trauma in an automobile accident. A Fire Rescue vehicle, in accordance with the Trauma Network Plan, bypassed a smaller hospital and brought the critically injured patient to Mount Sinai. Participation in a Trauma Network has a negative impact on mortality statistics.

5. Quality Assessment. Mount Sinai is committed to continuous review of its standard of quality. Our Quality Assurance Program has been in effect for many years. Virtually all admissions are reviewed for appropriate care while patients are in the hospital. Mortalities and morbidities are reviewed at medical staff departmental conferences and by medical staff quality assessment committees. Experience has shown that, to determine why a patient died, each patient's medical record must be reviewed to determine the individual circumstances surrounding the death.

We feel HCFA was ill-advised to again release misleading information and we are concerned that consumers will again mistakenly view the data as a guide to health care quality.

Sincerely,

Fred D. Hirt
President/Chief Executive Officer

lp

Comments on Health Care Financing Administration Mortality Data

St. Joseph's Hospital
3001 West Buffalo Avenue
Tampa, Florida 33677-4227

Provider Number 100075

St. Joseph's Hospital's mortality rates are within the Health Care Financing Administration (HCFA) predicted ranges in all areas reported. However, due to the potential for inaccurate conclusions, which may be drawn from the data, it is important to point out the flaws in the information scheduled for release.

First, mortality rates are not a measure of the quality of care patients receive. Selecting patient outcomes, such as deaths, is a method used by a hospital's Quality Assurance Department to identify cases which need further analysis. Without this review, the information is misleading and inaccurate.

Secondly, the mortality rates presented do not account for the severity of the patient's illness. Severity of illness is the most significant variable when predicting the chance of death.

Lastly, the mortality rates presented are neither valid nor reliable for the following reasons:

1) It is not known if the predicted death rates are "normal death rates". Hospital death rates are being compared with numbers that may be meaningless.

2) There may be errors in diagnostic categories. The diagnosis used as the cause of death may not be the reason the patient died. For instance, the information includes patients who died following discharge from the hospital,if they died within 30 days of admission. It is possible for a patient to be admitted for a heart problem, be discharged, and die as a result of an auto accident. This patient's death would be attributed to heart disease at the hospital. For those patients who died while hospitalized the same kind of error may occur. For example, a patient with cancer may be admitted with pneumonia, but die from the malignancy. This death would inaccurately be attributed to pneumonia.

With the aforementioned flaws in mind and the potential for misuse of the information, St. Joseph's Hospital feels the release of this information does not "offer insight into the results of patient care not previously available". It will not provide useful information to help consumers make more informed decisions about their health care.



NAPLES COMMUNITY HOSPITAL, INC.

(813) 262-3131 • POST OFFICE BOX 2507 • NAPLES, FLORIDA 33939

October 27, 1987

William L. Roper, M.D.
Administrator
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

We have reviewed the proposed Mortality Statistics Report and find no discrepancies except for the Deaths After Discharge. In nine cases (or 11% of the total) the deaths occurred in the hospital. These cases were erroneously included as deaths after discharge and should be deleted from that group.

The seventy-two cases cited were reviewed. Our analysis reveals that in fifty five, or 80% of the cases, the patients were of advanced years and affected by cancer, heart or lung disease. Appropriate and adequate health care was well documented. Death in these cases was anticipated and management discussed with the family. Appropriate community resources, e.g. Hospice, S.N.F. or a home health agency were utilized.

In the remaining eight cases documentation was sufficient to conclude that management was appropriate. We appreciate the opportunity to review this material before it is released to the public.

Sincerely,

William G. Crone
President
Naples Community Hospital

North Broward
Medical Center

201 Sample Road
Pompano Beach, Florida 33064
305/941-8300

October 16, 1987

Mr. Morford
Health Care Finance Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Interpretive Remarks Concerning HCFA Mortality Statistics

Dear Mr. Morford,

North Broward Medical Center fell within the Range of Predicted Mortality Rates for all diagnostic categories. To date North Broward Medical Center has systematically reviewed and evaluated cases from selected diagnostic groups primarily to: 1) assure that appropriate, high quality care was provided in all cases; 2) assess the validity of the HCFA model statistics; and 3) evaluate the appropriateness and reliability of this information as a quality of care indicator.

Upon review of the HCFA mortality data for North Broward Medical Center numerous errors were identified in the released information, such as the incorrect correlation of HIC numbers and patient names making patient identification suspect. Also noted was the inaccurate placement or grouping of patients into diagnostic categories. In many cases the principle diagnosis used by HCFA for patient categorization was found not to be relevant to the cause of death.

Furthermore, HCFA's mortality data does not take into account many factors and aspects of patient condition which have been found to have significant impact on patient mortality. Such considerations include, but are not limited to, the following:

1. Patient admission source: patients admitted to the hospital through the ER in critical condition.

2. Expected patient outcome: at the time of admission expiration was anticipated or reasonably anticipated with physician and family acknowledgement of such.

A Facility of
North Broward
Hospital District

North Broward
Medical Center

201 Sample Road
Pompano Beach, Florida 33064
305/941-8300

3. Code status of patients: patients were placed on a "no code" (do not resuscitate) status by the physician and family.

4. Severity of illness factors: patients within the same diagnostic category vary greatly in general health conditions with many patients having multiple concurrent acute and/or chronic disease processes.

After thorough review of the 1986 HCFA mortality data for North Broward Medical Center, coupled with the findings of individual patient's medical record review for appropriateness of care provided, North Broward Medical Center and its medical staff conclude that: 1) the model fails to consider or include a number of factors that significantly impact patient mortality and 2) neither the HCFA statistical model nor the data can be validated or used to measure hospital performance.

North Broward Medical Center feels that HCFA mortality data may prove useful in assisting hospitals in their internal quality assurance functions, but that it cannot, and should not, be used as a measure of comparison of hospital care and performance.

Sincerely,

Thomas J. Corder
Hospital Administrator
North Broward Medical Center

A Facility of
North Broward
Hospital District

NORTH GABLES hospital

October 23, 1987

CERTIFIED LETTER

William L. Roper, M.D., Administrator
Health Care Financing Administration
Washington D.C. 20201

Dear Doctor Roper:

The data used by HCFA indicate that a total of 492 Medicare patients were admitted to our facility in 1986. Our own records indicate that 747 Medicare admissions occurred in 1986.

Presumably the discrepancy reflects multiple admissions of individual beneficiaries, but there is no way of verifying whether the number of Medicare patients treated at our facility is correct.

Our analysis of the patient's specific data identified the following:

One incorrect date of death.

HIC	Surname	Date of Discharge	Date of Death
[redacted]	[redacted]	12/30/86	12/30/86

One incorrect discharge status: [redacted] was transferred to the hospital from a nursing home and was transferred back to the nursing home.

Enclosed is a copy of the individual beneficiary information for your convenience in making the corrections.

Sincerely,

Jane Jackson
Administrative Assistant

np

Enclosure

5190 S.W. 8th STREET / CORAL GABLES, FLORIDA 33134 / TELEPHONE: (305) 445-1364

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

North Miami Medical Center
We're making a name for ourselves

1701 N.E. 127th Street, P.O. Box 61000H, North Miami, Florida 33261-1707, 305/891-3550

October 26, 1987 AIRBORNE EXPRESS

Mr. Harvey Brook
Health Care Financing Administration
Health Standards & Quality Bureau
6325 Security Boulevard
Meadows East Building, Room 2-D 2
Baltimore, Maryland 21207

Dear Mr. Brook:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for Medicare patients for January 1, 1986 through December 31, 1986. After reviewing the data, we are pleased to find that our overall mortality rates fall within the predicted ranges established by HCFA in all categories.

North Miami Medical Center is a 359 bed acute care facility whose case mix includes many patients with major medical and surgical illnessess. We are a full service medical center offering care in many specialty areas including maternity and newborn care, rehabilitative medicine, psychiatric and substance abuse, as well as general medicine and surgery.

Approximately 50% of our patients are Medicare, and of these, approximately 75% are over 70 years of age.

We have approximately 10 Nursing Homes, Skilled Nursing facilities and Extended Care facilities within close proximity, all of whom transfer patients to our hospital on a regular and frequent basis.

Although we were within the range predicted by HCFA under Pulmonary Diseases, a careful analysis was done of these patients, which revealed the following:

- The average age of the expired patients in this category was 84 years.

- 67% of the expired patients were transferred from Nursing Homes. Upon Medical Staff review, it was noted that the majority of these patients were chronically ill with short life expectancy.

- 2/3 of the patients who expired had at least one or more of the significant Chronic Diseases as listed by HCFA; such as, Heart Disease and Carcinoma.
  Consequently, the probability of a negative patient outcome in these cases was high.

We are confident that the care delivered at North Miami Medical Center is of the highest quality. This is substantiated by ongoing Medical Staff Quality Assurance reviews of all patients, including all those who expire at this facility.

Thank you for the opportunity to respond to this data. We at North Miami Medical Center share HCFA's goal of ensuring that all individuals receive high quality health care.

Sincerely,

Ed Goffinett

Ed Goffinett
Chief Executive Officer

S2/HCFA

North Shore Medical Center Inc.

A Non-Profit Corporation

1100 N.W. 95 STREET, MIAMI, FLORIDA 33150
(305) 835-6000

RICHARD A. PAKAN
President & Chief Executive Officer

Based on hospital data during January 1 through December 31, 1986, North Shore Medical Center admitted 3,042 Medicare beneficiaries, of which 5.6% died during their hospital stay and an additional 1.7% within 30 days of their hospital admission for a variety of causes not necessarily related to their hospital admission, for an overall mortality rate of 7.3%, with an average age of 79 years.

The statistical data presented to HCFA is misleading since it does not take into consideration all admissions to the hospital in 1986. This skewed information cannot be interpreted as a measure of quality or the services provided by the institution.

For example: North Shore Medical Center provides a Community Cancer Center to serve the needs of South Florida. In 1986, we admitted 281 patients with the diagnosis of cancer - only 7.8% died within their hospitalization with an additional 6% dying within 30 days of their hospital admission. The overall mortality rate for patients with the diagnosis of cancer is 13.8%.

For additional information on actual mortality rates at North Shore Medical Center, please contact Ms. Doris Catalano, (305) 835-6183.

10/28/87

ORLANDO REGIONAL MEDICAL CENTER

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

The response and comments from Orlando Regional Medical Center, Orlando, Florida to the 1986 HCFA mortality data are attached. The list has been updated to correct any inconsistencies with ORMC records.

Sincerely,

Celia Roberts

Celia Roberts, RN, Manager
Quality Assurance

CR/zk

Attachments

1414 South Kuhl Avenue Orlando, Florida 32806-2093 (305) 841-5111

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

1986 HCFA Mortality Rates

ORMC Comments

According to the HCFA list, ORMC Medicare mortality rates fell within predicted ranges for all 16 categories with one exception, Sepsis, where ORMC's actual rate was below the predicted range.

The data used by HCFA indicate that of 4345 admissions, a total of 522 Medicare patients admitted to ORMC hospital died within 30 days of admission while 92 died after discharge.

Our own records indicate that 6314 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries during 1986.

Our own records also indicate that of the 430 Medicare patients who, according to the HCFA list, died as an inpatient within 30 days of admission, 2 were still alive at the time of discharge.

Additionally, 15 patients listed by HCFA as expiring after discharge in fact were inpatient mortalities, raising the inpatient mortality number from 430 to 445 and reducing the post-discharge mortality number from 92 to 77.

The errors in HCFA dates of admission, discharge, and death have been identified and the corrected data are attached.

It is impossible to determine whether the 77 patients who, according to HCFA, died after discharge did in fact die, as information concerning death after discharge is not included in the patient's medical record.

ATTACHMENT

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA			Deaths Verified by Hospital	
	In-hospital	Post-hospital	Total	In-hospital	Post-hospital
CA -- Cancer	63	14	77	64	13
CE -- Cerebrovascular Accidents	41	11	52	42	10
GC -- Gastrointestinal Catastrophes	18	1	19	18	1
GI -- Gastrointestinal Disease	27	2	29	27	2
GU -- Urologic Disease	6	2	8	6	2
GY -- Gynecologic Disease	2	0	2	2	0
HL -- Low Risk Heart Disease	16	4	20	16	4
HM -- Severe Chronic Heart Disease	38	5	43	41	2
HS -- Severe Acute Heart Disease	44	3	47	47	0
ME -- Metabolic/Electrolyte Disturbances	23	6	27	20	7
OP -- Orthopedic Disorders	2	1	3	3	0
PN -- Pulmonary Disease	47	12	59	48	11
RN -- Renal Disease	11	3	14	13	1
SE -- Sepsis	8	0	8	8	0
TR -- Severe Trauma	15	3	18	17	1
OP -- Ophthalmalogic Disease	0	0	0	0	0
UN -- Other Diagnoses	71	25	96	73	23
Total -- All Categories	430	92	522	445	77

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

AMI Palm Beach Gardens Medical Center

October 26, 1987

Helath Care Financing Adminstration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Please find enclosed Palm Beach Gardens Medical Center comments on the HCFA Mortality Data.

If you need any further information, please do not hesitate to contact me.

Sincerely,

Jack Barto

Jack Barto
Executive Director

JB:vs
Enc.

3360 Burns Road. Palm Beach Gardens. Florida 33410 305 622-1411

AMI Palm Beach Gardens Medical Center

COMMENTS ON THE HCFA MORTALITY DATA
PALM BEACH GARDENS MEDICAL CENTER
PROVIDER # 100176

The data used by HCFA indicate that a total of 1597 Medicare patients were admitted to Palm Beach Gardens Medical Center in 1986 and 148 died within 30 days of admission. Of these, 109 died while still a patient of the facility, while 39 died after discharge. Our own records indicate that 2605 Medicare discharges occurred in 1986. Presumably the discrepancy reflects multiple admissions that are indicative of more chronic disease patterns in our patients. The thousand admission discrepancy tends to leave more ambiguity than answers. Our records indicate that one of the one hundred and nine patients listed as dying in the facility is actually very much alive.

All of Palm Beach Gardens Medical Centers rates fell within the normal ranges with the exception of cerebrovascular accidents which was one percent better than the normal range.

It should also be noted that PBGMC has the highest acuity (a reflection of complicated and sick patients) in our five county health planning district. This severity is evidenced by the fact that most patients have six to eight major diagnoses. The facility also receives complicated transfers from other hospitals usually due to the specialized services we provide for cardiac care.

In summary, we feel that these statistics are indicative of the high level of care that is provided at Palm Beach Gardens Medical Center. Our Medical Staff and the facility perform ongoing review of mortality cases for appropriateness of care and we support the principle of communicating appropriate and meaningful quality of care information to consumers. However, we caution all reviewers in using simple rates for judging the quality of care provided by different facilities. The facility welcomes the opportunity to discuss the quality of care it provides.

3360 Burns Road. Palm Beach Gardens. Florida 33410 305 622-1411

AMI Palmetto General Hospital

October 28, 1987

Mr. William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

[redacted]

Dear Dr. Roper:

After analyzing the mortality information provided by the Health Care Financing Administration (HCFA), we have the following comments.

A review of our records indicate that of the total number of expirations included in the data, 18 cases expired after discharge from our hospital. The cause of death in these cases can be attributed to many extenuating circumstances and not necessarily to hospital intervention. The hospital maintains a thorough, ongoing review process, whereby each mortality case is reviewed for appropriateness and quality of care. In addition, it should be noted that the data may reflect more the nature of the patient's condition at admission rather than the outcome of the care provided at the hospital.

Very truly yours,

E Tudanger

Edward Tudanger
Executive Director

2001 West 68th Street, Hialeah, Florida 33016 305 823-5000

PPH
PALMS OF
PASADENA HOSPITAL
1501 Pasadena Avenue South
South Pasadena/St. Petersburg, Florida 33707
Telephone (813) 381-1000
A NATIONAL MEDICAL ENTERPRISES HEALTH CARE CENTER

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Attached are Palms of Pasadena Hospital's comments in response to your request of September 21, 1987, regarding the mortality information to be published in December.

We have some concern about the accuracy of the information. As noted in our comments, we found fairly significant discrepancies in the data, based on our review of aggregate statistics and a sample of approximately 26% of the cases reported. We were not able to validate the information on each of the 366 cases due to the time constraints and labor intensity of such a process, however, we feel there may be additional errors in the information.

Thank you very much for the opportunity to participate in this study. I hope our comments will be useful.

Sincerely,

Reynold J. Jennings
Executive Director

cc: B. Schochet
F. Tidikis

Attachments

RJJ/mn

COMMENTS ON HCFA MORTALITY DATA
Palms of Pasadena Hospital
St. Petersburg, Florida

INTRODUCTION

The data as presented is misleading and wholly inconclusive for a number of reasons:

1. The data does not take into consideration the severity of illness of a patient. Many of the DRGs are very broadly defined in terms of scope and severity of the reported disease, and existence of complicating or secondary diagnoses. These factors are not accounted for in the DRG groupings or in the model used to predict the mortality rates.

2. The mortality rates are based on the principle diagnosis, which may or may not have been the actual cause of death. For example, an elderly patient may have been admitted for a major joint procedure and later suffered a heart attack and died. The data would have listed major joint procedure (the principle procedure) as the cause of death. This would incorrectly skew the mortality rate for the hospital's major joint procedure category.

3. The absolute number of cases treated within a category could skew the mortality rate, For example, if a hospital treats a very small number of cases within a category, e.g., five cases, and due to the severity of the cases, two people die. This yields a forty percent mortality rate, which may high compared to verall national averages for many cases. Given the small number of cases treated, this mortality rate could be extremely misleading.

4. The data includes those patients which have died within thirty days of discharge from a hospital. However, no research has been done to determine if the cause of death was related to the hospitalization or due to a completely unrelated incident.

DATA VERIFICATION

The data used by HCFA indicate that a total of 3,039 Medicare patients were admitted to Palms of Pasadena Hospital, of which 366 reportedly died within 30 days of admission. Of these, HCFA reported that 298 died while still a patient of the hospital, while 68 died after discharge. Our own records indicate that there were 4,987 Medicare admissions in 1986, of which approximately 370 died while still a patient of the hospital. Furthermore, our records indicate that of the 68 patients reported as having died after discharge, 10 actually died while a patient in the hospital. It is impossible to determine the percentage of the 58 patients reported as dying after discharge who were, in fact, alive, as information concerning death after is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

INTERPRETIVE REMARKS

The hospital's actual mortality rate as reported by HCFA is within the range of the predicted mortality rate for each diagnostic category. When the hospital recalculated the actual mortality rate with the information provided by HCFA, the mortality rates decreased one to two percent in five of the diagnostic categories.

Palms of Pasadena Hospital's admissions are 75 to 77 percent Medicare, admitted from a predominantly elderly community. The hospital has a special care unit for respiratory illness and also offers hospice services for the terminally ill.

Results of Prelimary Medicare Record Review

The medical records of 95 of the 366 deaths reported were reviewed. The sample was composed of the 68 records reported as deaths after discharge and a ten percent random sample of all other patients in each diagnostic category. The average age of the patients was 80.2 as compared to the national average lifespan of 73.5. The predominant factors contributing to these deaths appeared to be the ages and general health status of the patients. A summary by diagnostic category follows.

DIAGNOSTIC CATEGORY	RECALCULATED MORTALITY RATE	AVERAGE AGE	ANTICIPATED DEATH RATE*
Cancer	21 %	81.2	73 %
Stroke	25 %	86.5	100 %
Gastrointestinal Catastrophes	11 %	74.3	100 %
Gastrointestinal Disease	4 %.	87.5	25 %
Urologic Disease	2 %	93.0	100 %
Low-Risk Heart Disease	4 %	82.0	60 %
Severe Chronic Heart	19 %	79.8	67 %
Severe Acute Heart	45 %	82.6	100 %
Metabolic/Electrolyte Disturbances	31 %	85.9	63 %
Orthopedic Disorders	2 %	76.0	50 %
Pulmonary Disease	21 %	81.5	100 %
Renal Disease	21 %	82.0	100 %
Sepsis	29 %	81.4	80 %
Severe Trauma	8%	86.2	0 %

* This percentage indicates, of the number of patients who expired, those patients where death was the result of the patient's condition at the time of admission and/or was the result of following the patient's wishes with respect to life-support measures.

INCORRECT DATA

The following information is for **clarification to HCFA only** and is **not intended for publication.**

[redacted]

Dates listed are dates of previous admission; patient was subsequently hospitalized from 12/09/86 - 12/17/86 and expired inhouse.

[redacted]

Date of death should be 12/13/86.

[redacted]

Date of admission should be 04/28/86.

[redacted]

Date of death should be 01/23/86.

[redacted]

Date of death should be 02/03/86.

[redacted]

Date of discharge and date of death should be 10/04/86.

[redacted]

Date of death should be 02/02/86.

[redacted]

Date of death should be 12/07/86.

[redacted]

Dates listed are dates of previous admission; patient was subsequently hospitalized from 03/19/86 - 03/21/86 and expired inhouse. Also, the principal diagnosis and procedure, when changed to reflect the information for the final admission, will put this patient in the UN category for all other conditions.

[redacted]

Dates listed are dates of previous admission, patient was subsequently hospitalied from 06/20/86 - 07/07/86 and expired inhouse.

[redacted]

The date of discharge and date of death should be 11/05/86.

Paul M. Pugh, F.A.C.H.E.
Administrator

Palms West Hospital

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Review
Hospital Mortality Information
PO Box 26684
Baltimore, Maryland 21207

To Whom It May Concern,

The purpose of this letter is to comment on HCFA's mortality rate data as it pertains to Palms West Hospital. All data has been reviewed; and we find the information to be administratively correct.

The following comments are offered: Twenty one (21) of thirty nine (39) patient records reviewed were noted to have been patients with Do Not Rescusitate (DNR) orders written into the record. DNR orders were placed on charts following physician consultation with family members after the patient's condition was considered to be terminal. Summary: 55% of patient deaths reviewed fell into the DNR category. With this explanation in mind, the adjusted mortality rate for Palms West Hospital is eight percent, or one percent under HCFA's predicted mortality range. Twenty four of the thirty nine patients reviewed were 70 years of age or older.

We appreciate the opportunity to comment.

Sincerely,

Paul M. Pugh, FACHE
Administrator

PMP/pm

cc: Chairman, Board of Trustees
Chief of Staff
Director of Nursing
Risk Manager
Medical Records Mgr.

P.O. Box 1150
Loxahatchee, Florida 33470-1150
Telephone (305) 798-3300

PAN AMERICAN HOSPITAL

Harvey Brooks
Health Standard and Quality Bureau
6325 Security Blvd. Rm.202
Meadows East Bldg.
Baltimore, Maryland 21207

Re: PATIENT MORTALITY STATISTICS

Dear Mr. Brooks:

Enclosed please find Worksheet 1 which includes corrections for deaths reported in regards to our facility. Also enclosed, please find the comments which we would like to be included in the published report.

If you have any questions, don't hesitate to call.

Respectfully submitted,

James Yeagley
Administrator

5959 N.W. 7th Street • Miami, Florida 33126 • 305-264-1000

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

PAN AMERICAN HOSPITAL

Pan American Hospital meets the needs of its surrounding (predominantly Latin) community. According to data from the 1980 Census of Population and Housing, almost 20% of the house holds in our primary service area are in the 65 plus age group. Therefore services provided by our units (Medical/Surgical, Orthopedic, Intensive Care and Cardiac Care) along with our Emergency Room attract a large geriatric population.

Upon reviewing data regarding our facility's mortality cases, our findings show 99% were in the 65 plus age group, 2/3 of these cases were in the age group greater than 80. The majority of these deaths are attributed to the fact that the patients were suffering from such high risk illnesses as cancer, severe acute and chronic heart disease, pulmonary disease, metabolic/electrolyte disturbances and stroke. Less than 1% of the deaths were under 65 years of age.

As a requirement to maintain our hospital's accreditation, we include mortality review within the activities performed within our quality assurance program. As a result of these reviews, we have found that the deaths occurred were expected due to the advanced age of our patients coupled with their diagnosis/condition at the time of admission and revealed patterns of care consistent with acceptable standards of practice.

5959 N.W. 7th Street • Miami, Florida 33126 • 305-264-1000

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	12	1	12	1
CE -- Cerebrovascular Accidents	8	2	10	0
GC -- Gastrointestinal Catastrophes	2	0	2	0
GI -- Gastrointestinal Disease	7	0	7	0
GU -- Urologic Disease	4	0	4	0
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	3	2	3	2
HM -- Severe Chronic Heart Disease	9	4	11	2
HS -- Severe Acute Heart Disease	9	1	10	0
ME -- Metabolic/Electrolyte Disturbances	6	4	7	3
OP -- Orthopedic Disorders	1	0	1	0
PN -- Pulmonary Disease	19	2	20	1
RN -- Renal Disease	4	2	6	0
SE -- Sepsis	1	0	1	0
TR -- Severe Trauma	2	0	2	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	16	7	18	5
Total -- All Categories	103	25	114	14

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

AMI Parkway Regional Medical Center

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper,

We are in receipt of HCFA mortality data specific to Parkway Regional Medical Center (PRMC). HCFA data reflects that PRMC's mortality rate falls within the predicted mortality rate in 15 of 16 diagnostic categories. After review of the category falling outside of HCFA's predicted mortality range, Severe Chronic Heart Disease, I would like to offer the following observations:

1. Error Correction - One patient listed as an expiration at PRMC could not be identified as a PRMC patient (see corrected patient listing). This corrected data will reflect a mortality rate of 31% which falls within HCFA's predicted mortality range for this category.

2. The average age of patients expiring in this category was 81 years of age.

3. Ten of the fifty-seven patients expired after discharge from PRMC. Of these ten patients, one patient left against medical advice and subsequently expired.

4. Seventy-six percent of the expirations in the category of Severe Chronic Heart Disease were admitted through the Emergency Room which reflects the severity of illness of these patients on admission.

5. Our patient listing of Medicare patients in this diagnostic category reflects a total of 317 patients with a known mortality rate of 16%. (This patient listing was obtained utilizing HCFA's selected ICD-9-CM codes. Patients with multiple admissions were counted once.) Obviously, there is a considerable discrepancy in mortality rates due to the unavailability of HCFA patient data to individual hospitals which makes comparison of similar data extremely difficult.

As admitted by HCFA, the HCFA statistical model cannot be validated and fails to consider a number of factors which significantly impact on mortality.

160 Northwest 170th Street, North Miami Beach, Florida 33169 305 651-1100

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Parkway Regional Medical Center maintains a high quality of patient care as evidenced by the Joint Commission of Accreditation of Hospitals with their issuance of an unconditional 3-year accreditation status. Additionally, the Professional Foundation of Health Care, Inc. has consistently maintained a minimal review status of patients based on quality of care and necessity of admissions to our facility.

We appreciate the opportunity that HCFA has provided for response to this data.

Sincerely,

Jay S. Weinstein
Executive Director

Peninsula Medical Center

264 South Atlantic Avenue
Ormond Beach, Florida 32074
(904) 672-4161

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

RE: Hospital Mortality Data
(Provider No. 10-0068)

Dear Doctor Roper:

I would like to take this opportunity to comment on the publishing of national hospital statistics regarding mortality rates.

Your communication of September 21, 1987 indicated that you cannot and do not recommend the use of the information by itself to make judgments regarding the quality of care of an individual hospital or to make comparisons among hospitals. Yet, this is surely what the news media and the general public will do. Most of the general population does not have a business/statistics background, therefore statistics are generally accepted as proven, which they are not.

Secondly, the methodology of assigning diagnostic categories is based on the principal diagnosis, which is not necessarily the cause of death. In our facility, for example, the first death listed in the orthopedic category really was caused by a massive cerebral infarct which had nothing to do with the principal diagnosis of "pathological fracture of the vertebrae". Although this facility did fall well within the "acceptable" limits, a lay person seeing the low predicted mortality rate for orthopedic disorders as "0" and ours as "2" may misconstrue that while 2 is low, they are going to aim for the hospital with "0" because that person certainly wouldn't want to take any chances when they were admitted for their bunionectomy. Having a medical background, I would want to know which facility had the most post-anesthesia deaths or post-operative pulmonary embolism or pneumonia deaths. I understand that event-

---

ually the PRO is expected to assist in discovering these quality issues, but in the meantime the general public will be improperly misled.

And finally, while your stated reasons for providing this information to facilities and practitioners may be valid, for the general public I feel that yet more fuel is being added to the fire especially in light of today's malpractice climate. Four years after the initiation of DRG's 90% of the Medicare patients admitted to this facility have not heard of the reasons for prospective payment and most think it was hospital initiated to save the facility money.

If your organization continues to feel the necessity for publishing such data, we, as health care providers, ask that prior and continuing education be provided to the person that ultimately suffers in the end ..... the patient.

Thank you for providing me with the opportunity to comment on the mortality rates information.

Sincerely,

Sharon G. Mullins, R.N.
Quality Assurance Coordinator

SM/mm

[redacted]

PLANTATION GENERAL HOSPITAL

October 26, 1987

Dept. of Health & Human Services
Health Care Financing Admin.
Health Standards & Quality Bureau
Hospital Mortality Information
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Sir:

Thank you for affording us the opportunity of analyzing the 1986 Mortality data for our hospital.

We respectfully request that the following comments be included in your December 1897 release of this mortality data to the public.

Comments:

Prior to the release of the data, a quality assurance mechanism had already been established for many years at Plantation General Hospital which included an ongoing review of all mortality and morbidity within the facility. Please note that all of our mortality statistics were well within the HCFA range of acceptance.

This 1986 mortality data was subjected to Peer Review by our physician analysts, hospital medical staff representatives and quality assurance professionals. Reports of their findings were rendered to the Executive Committee of our medical staff. The methology used in our evaluation of post-discharge deaths included direct communication with each patient's attending physician by our hospital analyst.

It is significant to note that our demographic area is nationally recognized as a retirement area with a population of aging Americans twice that of the national average. Our normal clientele includes a high number of high risk categories such as renal failure, cancer, strokes, etc.

[illegible]
An Affiliate of
HEALTHTRUST INC. The Hospital Company

Please note also that our hospital's scope of services is wider than that normally found in a general acute care hospital, i.e. cardiac cath lab, chronic & acute renal services, etc. Twenty-one percent (21%) of our beds are devoted to intensive care as compared to six to ten percent (6%-10%) normally found in other community hospitals.

The following information from our analysis is significant to any evaluation of the HCFA data:

A. The average age of the 148 patients was 72 years. Of these, 74 were females with an average age of 79 years and an equal amount were males (74) with an average age of 64. This average age difference of fifteen (15) years is noteworthy.

B. It became evident from a review of the data that a number of patients were transfers from nursing homes to our facility during an acute episode. The patients were subsequently returned to the original nursing facility when their condition was again subacute and they expired in the nursing home. This is a recognized occurance in today's medical care scene in that many patients who are about to expire require no more than subacute or custodial care during the last days of their life, and hospitals have been encouraged by peer review organizations (PRO) to return these subacute patients to their original nursing home. Telephone calls were made by our physician analyst to nursing homes to verify each patient's course of treatment and final outcome. In every instance, it was throughly evident that each patient was followed professionally by a medical doctor. Over 50% of the patients who died outside of the hospital (15 out of 26) died in a subacute care environment, i.e. in Nursing Homes.

C. Our findings also indicated that in more than one instance there was a patient who could not cope with his medical condition, and apparently chose to end his own existence through failure to adhere to medical treatment. There were indications in other cases that similar circumstances may have been involved as the cause of death.

D. A number of families wanted the patient to return to their home for the dying process. This family wish was complied with in all cases.

E. In a number of instances, especially in patients suffering chronic severe heart disease, family members requested a "no code" status for the patient. This is often in compliance with The Life Prolonging Procedure Act/"Living Will" declaration which permits the patient to die naturally and not artificially prolonging the dying process. These patients were terminally ill patients and this decision by the family/patient is usually made in order to ease pain and suffering during the last hours of life and to allow the patient to die with dignity.

In conclusion Plantation General Hospital is unique among area facilities because of our intense services and our scope of practice. Our medical staff contains many subspecialists who are Board Certified and whose services are critical in the area, and are found only in our facility.

We welcome the review of our data by the Peer Review Organization (PRO) especially since our previous relationship with them has indicated that we have been in total compliance with all PRO program requirements.

End of Comments

We are hopeful that the Health Care Financing Administration will continue this program of releasing refined data of this type because it will not only serve to improve the monitoring of our service but will also assist us in meeting our committment to quality patient care.

Sincerely,

John A. Corrado

John A. Corrado, FACHE, LNHA
Assistant Administrator

JAC:sh

Riverside Hospital
2033 Riverside Avenue
Jacksonville, Florida 32204
[904] 387-7002

Charles P. Hayes, Jr., M.D.
President

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Re: Comments on the HCFA Mortality Data

Dear Dr. Roper:

The data used by HCFA indicates that a total of 143 Medicare patients died within 30 days of their last admission during 1986 at Riverside Hospital, Jacksonville, Florida. Our analysis of the limited patient data furnished by HCFA confirms that 110 in-hospital deaths occurred within 30 days of their last admission during 1986. The difficulty in obtaining accurate data regarding actual causes and dates of death following discharge from various sources renders us incapable of confirming all of the deaths within the HCFA sample and time frame (30 days post admission). Variables affecting the data such as transfers to other hospitals, nursing homes, and death certificates in the sole possession of families and/or funeral homes restricts confirmation of date and cause of death.

Confirmed HCFA data discrepancies are as follows:

PAT. ID# HIC	SUR-NAME 1st 6 LTRS	DIAG CATE-GORY	AGE	SEX	ADM. DATE	DIS-CHRG DATE	DATE OF DEATH	PRIN. DIAG-NOSIS	PRIN. PRO-CEDURE
[redacted]		CA	80	M	9/4/86	9/21/86	9/21/86	1625	3324
(Died in hospital on 9/21/86, NOT on 9/30/86 after discharge.)									
[redacted]		TR	95	F	6/3/86	6/7/86	6/12/86	82123	7905
(Patient expired of Cancer of the breast, NOT Trauma; Death Certificate indicates 6/12/86 as date of death, NOT 6/30/86.)									

Without the detailed information concerning the billing data available to HCFA in computing both the actual and predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your sample analysis.

However, according to HCFA's sample formula calculations and predictions for mortality rates, Riverside Hospital did not have any diagnostic categories which fell outside of the HCFA predicted mortality rates.

In the absence of useful data from HCFA we were unable to calculate any differences from those arrived at by your staff.

Such comparisons based on questionable confidence levels of data and chance predictions are not, in our opinion, a scientific means of quality assurance or professional review.

Statistical analyses of mortality rates can do no more than screen for further review. HCFA will indeed raise some important questions about certain institutions without having the ability to answer or explain such issues. Quality judgments can only be made after reviewing the information contained in a patient's medical record. Accredited hospitals regularly review their own data for quality and appropriateness of services and to determine the extent and corrective actions necessary to maintain certain quality standards. It is to this end that I suggest HCFA direct its attention and our tax dollars. Work with the health providers in what should be our common goal of maintaining certain affordable levels of quality.

Yours sincerely,

Charles P. Hayes, Jr., M.D.
President

CPHjr:sz

Sacred Heart Hospital

5151 N. 9th Ave. P.O. Box 2700 Pensacola, FL 32513-2700 (904) 474-6102

Office of Executive Vice President

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Mortality Data Comments [redacted]

Dear Sirs:

The following comments are intended for publication with our hospital's mortality data:

> We note the mortality rates for Sacred Heart Hospital are within HCFA's predicted ranges. HCFA's records indicate that 3921 Medicare admissions occurred in 1986. Of these, a total of 502 Medicare patients admitted to Sacred Heart Hospital died within thirty (30) days of admission. Analysis reveals that 410 died while still a patient of the hospital and 92 died after discharge.

Sincerely,

James R. Hardman

James R. Hardman, FACHE
Executive Vice President

/jb

HCA Santa Rosa Medical Center

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Rate
Hospital ID Number 100124

Dear Dr. Roper:

The following comments are offered in response to the mortality rate data furnished to this facility by your agency:

The data do not take into account the severity of the individual patient's injury or illness. Patients in critical condition from accidents, with massive insults to a major organ - i.e. heart attacks and strokes, or with terminal illnesses are admitted to the hospital when death is the expected result.

Ninety-five percent (95%) of the patients making up these statistics had multiple hospital admissions for the year and their prognosis was listed as poor.

The age of the patient is an important factor not considered. Ninety-four (94%) of the patients included in our facility's statistics were over the age of 75.

Elderly patients usually have more than one medical problem. The cause of death, therefore, may not be the problem necessitating the admission.

The data included patients who die within 30 days after hospital admission, whether or not the patient is in the hospital at the time of death. Death may often result from a condition not at all related to the last hospital admission. Six (6) deaths reflected in the mortality rates were not Santa Rosa Medical Center hospital deaths.

The majority of these patients were in the final stages of illness and the facility had been requested, by the patient

1450 Berryhill Road
Milton, Florida 32570
Telephone (904) 623-9741
A subsidiary of HCA The Healthcare Company

or their family, that no action be taken to prolong life.

The "all causes" category list 426 cases and a mortality rate of fourteen percent (14%). In fact, Santa Rosa Medical Center admitted 793 medicare patients. The actual mortality rate when all admissions are considered is six percent (6%).

The DRG system was developed by Health Care Financing Administration to monitor medicare billing, not the quality of care. We submit that this statistical tool is being used to do a job it was never intended for. This can create to the puhlic a false impression of the over all quality of care at a hospital.

We appreciate the opportunity you have extended by allowing us to respond prior to publication.

Sincerely,

Jon C. Trezona
Administrator

JT/bgm

SEVEN RIVERS
COMMUNITY HOSPITAL
6201 N. Suncoast Blvd. • Crystal River, Florida 32629 • Telephone (904) 795-6560
A SUBSIDIARY OF NATIONAL MEDICAL ENTERPRISES, INC.

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Medicare Provider #10-249

To Whom It May Concern:

In reviewing the Health Care Financing Administration data our hospital feels very strongly that the statistical analysis can do no more than identify a high risk diagnostic category. The data as presented is misleading and wholly inconclusive for a number of reasons:

1) The data does not take into consideration the severity of illness of a patient. Many of the DRG's are very broadly defined in terms of scope and severity of the reported diseases, age distribution of the patients treated, and existence of complicating or secondary diagnoses. For example, an otherwise healthy 66 year old woman with heartbeat irregularities may be hospitalized for the insertion of a pacemaker. Another pacemaker patient, a 93 year old male, suffering from a massive heart attack and congestive heart failure could be categorized under the same grouping released by HCFA. These factors are not accounted for in the DRG groupings or in the model used to predict the mortality rates. All patients at our hospital in the severe, acute heart disease (HS) category had massive heart attacks, were treated in the Intensive Care Unit (CCU), had cardiac specialists, suffered cardiac arrest, and expired. Contributing to their deaths were pre-existing conditions.

   Eighty-two percent (82%) had a history of previous heart disease and forty-five percent (45%) had a history of previous heart attack. Seventy-three percent (73%) of the total had complications related to the heart attack and/or other disease processes. The average age of these patients was 78 years old.

2. The mortality rates are based on the principle diagnosis, which may or may not have been the actual cause of death. For example, an elderly patient may have been admitted for a major joint procedure and later had a heart attack and died.

The data would have listed major joint procedure (the principle diagnosis) as the cause of death. This would incorrectly skew the mortality rate for the hospital's major joint procedure DRG.

In review of the Metabolic Disorders (ME) at our hospital, thirty percent (30%) arrived at our Emergency Room unresponsive and in a terminal condition, expiring within an average of seventeen (17) hours. Seventy percent (70%) had pre-existing conditions, namely, cancer, which would cause the electrolyte/metabolic disorder. The remaining thirty percent (30%) had cardiac/lung disorders. It is interesting to note that seventy percent (70%) of our patients in this category (ME) had living wills documenting their wish for no heroic measures. The average age of these patients was 74 years old (65-94).

3. The absolute number of cases treated within a DRG could skew the mortality rate. For example, suppose a hospital treats a very small number of cases with a DRG, (e.g. five cases), and due to the severity of cases within that DRG, two people die. This yields a forty percent (40%) mortality rate, which may be high compared to overall national averages for many cases. Given the small number of cases treated, this mortality rate could be extremely misleading.

4. The date includes those patients which have died within a thirty day discharge date from the hospital. However, no research has been done to determine the cause of death. Was it related to the hospitalization or was it for a completely unrelated incident. In review of the Metabolic Disorders (ME), only fifty percent (50%) actually died while a patient.

As you are aware, hospitals are subject to a stringent series of checks and balances aimed at ensuring the delivery of quality health care. First, hospitals conduct ongoing internal assessments aimed at monitoring quality within their own facilities. <u>All</u> deaths occurring within the hospital are reviewed by a designated committee of physicians.

Second, hospitals are subject to state and county health care licensing criteria which included standards that must be adhered to by all hospitals. Without qualifying for state and municipal certification, hospitals cannot operate.

Third, the Joint Commission on Accreditation of Hospitals (JCAH), a private, non-profit organization of healthcare professionals, stringently reviews the quality assurance activities of hospitals and their medical staffs prior to awarding its coveted endorsement.

The JCAH evaluates hospitals every three years to assure that objective criteria are used to measure quality of patient care, in addition to reviewing actual patient cases in an effort to make certain that quality care is being provided.

Finally, the Professional Review Organization (PRO), the federally contracted "watch dogs," are mandated by law to monitor hospital utilization for all Medicare beneficiaries, ensuring that the care delivered is necessary and appropriate.

Sincerely,

Michael Heindel
Administrator

MH/vpm

SHANDS HOSPITAL
at the University of Florida

UNIVERSITY OF FLORIDA
COLLEGE OF MEDICINE

GAINESVILLE, 32610

October 26, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201

Dear Dr. Roper:

As representatives of Shands Hospital and the physicians of the University of Florida College of Medicine, we present the following comments on the mortality data provided by HCFA regarding Medicare patients treated at Shands Hospital during 1986. Shands has a long-standing commitment to a rigorous program of quality assurance, and we support HCFA's goal of focusing attention on this important issue.

In order to interpret any data on patient outcomes in proper perspective, it is essential to understand the special position that Shands occupies in the State's healthcare delivery system. As a university-based academic referral center, Shands offers highly specialized services for the diagnosis and treatment of very complex or very severe illnesses. *More than three-fourths of the patients treated at Shands during 1986 came from outside our county, and more than one-fifth of our patient days were for intensive care services.*

These factors are clearly related to mortality. *For example, 40 percent of Shands' patients who were shown in HCFA's data to have died were transferred to Shands from other healthcare institutions, and 56 percent of these patients received ICU services while at Shands.*

HCFA's model for expected mortality considers some key patient characteristics such as these, as a basis for computing a reference range against which each hospital's actual experience is compared. *The data provided by HCFA indicate that, in every clinical category, the mortality rate for Shands' patients is either within or below the expected range.*

Certainly these data cannot be construed to suggest any problems with quality of care at Shands. *Still, we must express serious reservations about publication of these data in this format.*

First, HCFA's use of the term "mortality rate" differs so markedly from the general use of the term--and from its strict epidemiological definition--as to encourage serious misinterpretation. The HCFA data do not measure "risk of dying per admission," but rather the percent of (1) MEDI-

CARE patients who die (2) WITHIN 30 DAYS of (3) THEIR LAST ADMISSION DURING THE YEAR to any hospital (4) REGARDLESS OF WHETHER THEY DIE in the hospital or AFTER DISCHARGE, and (5) REGARDLESS OF whether THE CAUSE OF DEATH was related to the reason for hospitalization. Perhaps a term such as "Medicare Mortality Index," which does not carry a preconceived intuitive meaning, would aid the public in more accurately interpreting the data.

Our second major concern is the way HCFA has presented the raw mortality data for each hospital in comparison with a risk-adjusted "expected range." Statistically, no meaning can be attached to the location of the actual hospital rate within the expected range, only to whether it is above, below, or within the range. Giving numerical values for the actual rates facilitates invalid comparisons--between the actual value and the boundaries of the expected range, as well as between hospitals that may treat very different types of patients.

Third, we question the publication of the results of HCFA's methodology for computing expected "mortality rates" before submitting the methodology itself for constructive debate. The clear implication of this publication is that hospitals whose actual rates exceed the expected range may have problems related to quality of care, but without a better understanding of the model, it is impossible to tell whether the problem lies with the hospitals or with HCFA's statistical model. It seems that HCFA's stated aim of addressing quality of care issues would be better served by an emphasis on first establishing the validity of the model, before focusing attention on the performance of individual hospitals.

Our final major concern is with the accuracy of the data itself, which is important not only as it reflects on the performance of an individual hospital, but because every error affects the statistical calculations for all hospitals, not just those whose data are erroneous. Specifically, two deaths appear to have been incorrectly attributed to Shands:

- [redacted] -- The date of death is recorded as 2/28/86, but review of the patient's record reveals a discharge date of 2/17/86, with follow-up visits on 2/25/86 and 4/14/86. [redacted] confirmed the patient's death in Georgia on 5/28/86, well beyond 30 days after the patient's last [redacted]

- [redacted] -- These data show that the patient was discharged from Shands on 9/29/86. Actually, this patient was transferred to an *inpatient* hospice unit at Methodist Hospital in Jacksonville, Florida. The patient expired on 9/5/86.

Review of the records also revealed the following minor inaccuracies in category assignments and dates:

[redacted]-- The patient had an upper GI hemorrhage and thus should fall into category GC, rather than GU.

[redacted]-- The principal diagnosis was chronic skin ulcer (707), and the patient should fall into category UN, rather than PN.

[redacted]-- The diagnosis was common bile duct obstruction (576.2) and thus should fall into category GI, rather than UN.

[redacted]-- The patient had cancer and thus should fall into category CA, rather than UN.

[redacted]-- The patient was admitted because of trauma and thus should fall into category TR, rather than UN. The patient eventually expired from a myocardial infarction.

[redacted]-- HCFA data shows the last admission as 1/29/86 to 1/30/86, but the actual last admission was 2/13/86 to 2/21/86. The patient expired on 2/21/86.

[redacted]-- HCFA data shows the date of death as 10/29/86. The patient actually expired on 10/27/86.

We appreciate HCFA's efforts to increase public awareness of the quality of healthcare. This parallels Shands Hospital's own internal commitment to quality assurance. We continuously review the quality of patient care that we provide, against both internal and external standards. Variances from expected clinical outcomes are carefully assessed, in an attempt to discover opportunities to further improve our care. We would welcome an opportunity to work with HCFA to refine the statistical model upon which this publication is based and to participate in the development of additional, more sensitive measures of healthcare quality.

Sincerely yours,

Paul E. Metts, CPA
Chief Executive Officer
Shands Hospital

William B. Deal, MD
Dean, College of Medicine
University of Florida

cc: The Honorable Lawton Chiles
United States Senate

The Honorable Bob Graham
United States Senate

The Honorable Buddy MacKay
United States House of Representatives

Dennis S. O'Leary, MD
President, Joint Commission on Accreditation
of Healthcare Organizations

Charles B. Reed, PhD
Chancellor, State University System

Patricia C. Haynie, PhD
Vice Chancellor for Health Affairs
State University System

Marshall M. Criser, Jr., Esq.
President, University of Florida

Mr. Alvin V. Alsobrook
Vice President for University Relations
University of Florida

David R. Challoner, MD
Vice President for Health Affairs
University of Florida

Gerold L. Schiebler, MD
Associate Vice President for Health Affairs
for External Relations
University of Florida

7400 S.W. 62nd Avenue
Miami, Florida 33143
(305) 661-4611

SMH SOUTH MIAMI HOSPITAL

October 26, 1987

Mr. Harvey Brook
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
6325 Security Blvd.
Meadows East Building D-2
Baltimore, MD 21207

Dear Mr. Brook,

This is a duplicate of response submitted to Health Care Financing Administration Post Office Box. As you know courier services can not deliver to a Post Office Box. This copy is provided in the event original not received by deadline for acceptance.

Thank you for providing this alternative.

Sincerely,

Christine B. Fernsler

Christine B. Fernsler
Director
Quality Assurance

CBF/ces

(Enc.)

7400 S.W. 62nd Avenue
Miami, Florida 33143
(305) 661-4611

SOUTH MIAMI HOSPITAL

October 23, 1987

William L. Roper, M.D.
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, Maryland 21201

RE: Mortality Statistics - Provider Number 100154
1986

Dear Dr. Roper,

South Miami Hospital appreciates the opportunity to respond to the release of hospital mortality data for calendar year 1986.

South Miami Hospital is 528-bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full-service medical center offering care in specialty areas of oncology, cardiology, rehabilitative medicine, obstetrics, addiction treatment and pulmonary medicine, as well as general medicine and surgery.

The data provided has been compared to our records and the Quality Assurance Department has re-reviewed all individual cases in the following areas. Additionally, each Department of the Medical Staff reviews all mortality cases for quality and appropriatenss of care monthly.

CANCER

H.C.F.A. Mortality Rate = 25% 60 Mortalities out of 238 cases

75% of these cases entered the institution in a terminal state and supportive/comfort measures only were provided. 15% of the cases then expired in the Hospice Program for terminally ill patients

*** Adjusted Mortality Rate is 8% ***

GASTROINTESTINAL CATASTROPHE

H.C.F.A. Mortality Rate = 15% 9 Mortalities out of 68 cases

18% of these cases were terminal at admission and admitted for supportive/comfort care only

45% of these cases expired from complications of other chronic conditions. These deaths were not the result of the gastrointestinal catastrophe (i.e. neuro infarct - comatose on admission, metastatic cancer, renal failure with pulmonary edema (2), massive pulmonary emboli).

*** Adjusted Mortality Rate is 3% ***

SMH

LOW RISK HEART DISEASE

H.C.F.A. Mortality Rate = 5% 15 Mortalities out of 299 cases

Mean age for Medicare mortality population = 73

20% of the mortality patients were patients transferred to our facility from other hospitals for extensive high risk cardiac interventions.

13% of the mortality patients were supportive/comfort care only and were considered terminal at admission

Total hospital population admitted for this category = 1574 (Medicare + Non-Medicare patients) data indicates those patients suffered only a mortality rate of 1%

*** Adjusted Mortality Rate for this category is 3-4% ***

SEVERE ACUTE HEART DISEASE

H.C.F.A. Mortality Rate = 36% 24 Mortalities out of 66 cases

21% of these expirations were considered terminal at admission with supportive/comfort care only

25% of these expirations were admitted to the hospital's services in "cardiogenic shock" which in and of itself carries a recognized mortality rate of 95% +

46% of the total mortalities and conditions complicated by diabetes

*** Adjusted Mortality Rate is 19% ***

SEPSIS

H.C.F.A. Mortality Rate = 27% 4 Mortalities out of 15 cases

Total Hospital Population for this category 29 cases with 4 mortalities

75% (3 cases) of mortality patients were supportive/comfort care only and were considered terminal at time of admission

75% of mortality patients (this includes 3-2 of cases described above) were transferred to our facility from Nursing Homes and were severely compromised by numerous co-morbidity factors

*** Adjusted Mortality Rate is 6% ***
(Adjustment made for terminal patients only)

RENAL DISEASE

H.C.F.A. Mortality Rate 30% 7 Mortalities out of 27 cases

Total Hospital Population for this category is 77 with a mean age of 62 years.

The mean age for the mortalities was 80 years

71% of the expirations were admitted for supportive/comfort care only and were considered terminal at admission

21% of the expirations were admitted in a comatose state

*** Adjusted Mortality Rate is 11% ***

SMH

As a facility dedicated to quality patient care and optimum outcomes for the populations we serve, our Medical Staff, through the Quality Assurance process, continually review all mortality cases, as well as other indicators, to ensure the best care possible is delivered to each and every patient.

Sincerely,

Merrill W. Crews
President
South Miami Hospital

Fred Doerper
President
Board of Governors
South Miami Hospital

Peter Citron, M.D.
President
Medical Staff
South Miami Hospital

CLB/ces

cc: Florida Hospital Association
Members of South Miami Hospital Medical Staff
Employees of South Miami Hospital

South Seminole Community Hospital

October 14, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

RE: Medicare Mortality Rates

Dear Dr. Roper:

We have reviewed HCFA's mortality information for our facility and have made comments regarding this data on the attached report. Also attached are the HCFA data sheets with two cases highlighted in yellow that have been coded by HCFA as expired at the time of discharge. These two particular cases have been researched and we have determined by medical record review that these patients were discharged alive.

We appreciate the opportunity to review and respond to this this information prior to its release to the public. However, we wish to point out that it took two people at this hospital three days to analyze your data and statistical methodology. As such, we have a major concern with HCFA's rationale for releasing this information to the public without some benefit of interpretive standards. We hope you share our concern for misinterpretation potentially resulting in public mistrust toward hospitals. Of chief concern is your admisison in you letter of September 21, 1987, that you "want <u>eventually</u> to reach the point where the issuance of information will allow the user to make judgements on the quality of care provided by individual institutions." This statement implies that your Medicare mortality analysis is not quite ready for meaningful public consumption.

Sincerely,

James W. Poucher
Administrator

Evelyn Matthews
Dir. Quality Assurance

JWP/kk

Attachment 5
111 West State Road 434
P.O. Box 521607
Longwood, Florida 32752-1607
Tel. (305) 767-1200

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

South Seminole Community Hospital

DATA VERIFICATION OF HCFA MORTALITIES

1986 HCFA DATA

The data used by HCFA indicates that a total of 96 Medicare patients admitted to South Seminole Community Hospital died within 30 days of admission . Of these, 80 died while still a patient of the hospital, while 16 died after discharge. Our own records indicate that 1,260 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at South Seminole Community Hospital is correct.

SOUTH SEMINOLE COMMUNITY HOSPITAL DATA

South Seminole Community Hospital records indicate that 78 Medicare patients died within 30 days of admission while still an inpatient; 18 were still alive at the time of discharge. NOTE: Two patients were coded by HCFA as being dead at the time of discharge and upon review of hospital records, South Seminole Community Hospital notes that these two patients were discharged alive.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

INTERPRETIVE REMARKS

According to HCFA's statistics, in one of the diagnostic categories (HS - Severe Acute Heart Disease), the hospital's actual mortality rate falls outside the range of the predicted mortality rate. However, according to South Seminole Community Hospital's records, there are two patients included in this category, who died after discharge. After correcting the error in the recording of these two deaths, South Seminole Community Hospital falls within the predicted mortality range for HS. Therefore, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate is zero.

UNIQUE SERVICES RESULTING IN HIGHER THAN AVERAGE MORTALITY

The average age of Medicare patients treated at South Seminole Community Hospital is 73 years. Also, it is noted that the majority or our Medicare admissions fall in the high risk diagnostic categories, which would suggest that the patients admitted have severe medical circumstances influencing their outcome.

555 West State Road 434
P.O. Box 521607
Longwood, Florida 32752-1607
Tel. (305) 767-1200

South Shore Hospital
AND MEDICAL CENTER
630 ALTON ROAD
MIAMI BEACH
FLORIDA 33139
(305) 672-2100

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
6300 Security Boulevard
Room 2D2 Meadows East Building
Baltimore, Maryland 21207

RE: Hospital Mortality Information
Medicare Provider Number : 10 - 0172

Dear Dr. Roper:

South Shore Hospital and Medical Center, a Geriatric Specialty Hospital, serves the southern portion of Miami Beach. Due to the tremendous uniqueness of our community's demographics, South Shore Hospital is nearly 90% geriatric with a median patient age of 81 years. There are twice as many patients over age 85 as under age 65. These patients have multiple chronic conditions with a mean number of diagnoses of 4.8.

Although the actual mortality rate is well within the range of predicted mortality rates, the uniqueness of our community and patients (age, chronicity, etc.) is certainly a major factor in the treatment of frail elderly patients.

Sincerely,

Barbara Zubkoff

Barbara Zubkoff, MBA
Assistant Administrator

/jc

AMI Southeastern Medical Center

October 20, 1987

Dr. William Roper
Office of the Administrator
Health Care Financing Administration
Dept. of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

We at AMI Southeastern Medical Center in North Miami Beach, Florida (#100036) welcome the opportunity to comment concerning release of the 1986 mortality data. Our hospital and medical staff routinely perform ongoing review of all care rendered in the hospital including all mortality cases. These patient records are routinely reviewed for both appropriateness of care and the quality of care rendered by the hospital and our medical staff. We support the principle of communicating appropriate and meaningful quality of care information to our consumers.

In reviewing the mortality data for our institution, we would like to provide further clarification concerning several areas. They are as follows:

1. The hospital's overall mortality data, as reported by your department, is within the predicted range for this study of Medicare patients. We are very proud of the fact that our expected mortality rate is within the range as computed by the Health Care Financing Administration.

2. The average age of the patients in this sample was more than 82 years. This is an important indicator because generally patients over age 75 may have less resilience to illness. It is important to note that our average Medicare mortality in this study was significantly above the life expectancy of the average population of the United States.

3. In reviewing the data we found that 23% of the patients reported within our mortality statistics did not expire in the hospital. Since their expiration occurred within 30 days after discharge, they have been included in our sample as per your protocol. It is very difficult to verify the circumstances of out-of-hospital deaths. Death may occur for a number of reasons including accidents, the continuing deterioration of a patient's condition, or poor care outside the hospital.

4. An important measure of the severity of illness of a patient is their status upon admission. In our sample study, 89% of the total deaths occurring in our facility were patients admitted either through the emergency room or directly from nursing homes. The patient's general health status, stage of illness, psychological condition and degree of family support may be severely compromised in these patients. Patients admitted through the

1750 N.E. 167th Street. North Miami Beach. Florida 33162 305 945-5400

emergency department generally are higher risk candidates for surgery or treatment than others. Patients admitted through nursing homes tend to be sicker than those admitted who are still able to care for themselves at home.

5. The data, as released by the Health Care Financing Administration for our hospital, had a 20% error rate according to our study. For instance, one patient listed as a death in our facility was not admitted to this hospital according to our records.

6. It is difficult to review causes of death when the data is broken down by specific diagnoses. Generally patients admitted to a hospital have more than one medical problem. The cause of death is usually not related to the principal diagnosis alone. Even in reviewing your data as submitted to us, broken down by specific diagnostic categories, our death rate is within your predicted range in over 98% of the cases.

Finally, a review of this data on our Medicare patient discharges shows a patient population with higher than average risk of death. We are pleased to see that even given the above, the death rate for our patient population is within your expected range as produced by the Health Care Financing Administration. Our patients generally have chronic degenerative conditions, a less than ideal pre-hospital care situation, and their average age is substantially more than the average life expectancy leading us to think that their ability to withstand a substantial illness process is reduced.

We look forward to using this data to focus our Quality Assurance activities and welcome any additional suggestions from your organization. We review all mortalities internally through our medical staff peer review process and we believe that this is the most effective mechanism for quality review.

Due to the formula utilized in this statistical sampling method, the data can not be relied upon as a measure of quality of care rendered in our facility. Several points need to be kept in mind when reviewing the data:

a. Death rate percentages are available for individual hospitals, figures do not reflect those physicians who practice at more than one hospital.

b. Although the information published applies only to Medicare, it can create a false impression of the overall quality of care at a hospital.

c. Patients and families of those admitted to the hospital in final stages of illness often ask that no action be taken to prolong life. The data does not correct for these family requests.

d. Risk of death can be affected by a patient's genetic background or the lack of money to afford earlier health care.

e. Certain hospitals generally treat more seriously ill patients than other hospitals. The data does not adjust for the severity of illness of the patient population.

We look forward to constructively utilizing the data that you are releasing, and thank you for the opportunity to comment on this data. Once again I would like to point out our support for the principle of communicating meaningful quality of care data to the health care consumer and remain available to address any issues that may be of mutual concern.

Sincerely,

Jose Fernandez
Executive Director

/jae

10/20/088

Southwest Florida Regional Medical Center
Fort Myers Community Hospital

Another
Basic
American
Medical
Company

October 27, 1987

Medicare Provider No. 100220

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Sir:

I am writing in response to your letter of September 21, 1987, regarding the forthcoming publication of selected mortality information.

While we appreciate the opportunity to comment on these data before publication, the allotted time frame was not sufficient for a complete review. We have focused, therefore, on a review of cases under cardiovascular care, one of our leading DRG's.

Within this area of care, I offer the following specific comments:

- Southwest Florida Regional Medical Center is a regional referral center for cardiac surgery and as such can expect to receive many severely ill patients.

- As a leader in the treatment of cardiac patients, Southwest Florida Regional Medical Center is likely to receive complex cardiac cases, admitted for medical reasons, then referred for surgery.

- A review of individual cases, specifically "low risk" heart cases, found that these cases were misclassified and should have been listed as "high risk" heart cases. Co-existing conditions were not taken into account.

3785 Evans Avenue
Fort Myers, Florida 33901
(813) 939-1147

- In all cases reviewed, care was found to be appropriate and within the acceptable standards of practice. All cases had also been previously reviewed at mortality review meetings and the same conclusions reached.

- Patients who died within 30 days following discharge were reviewed. Discharge was deemed appropriate and quality of care was more than acceptable.

I also offer the following general comments in relation to all of the mortality data provided.

- The statistics represent only the hospital's Medicare admissions for 1986.

- Emphasis should be placed on the fact that this is a "statistical analysis" and such analysis cannot measure "quality".

- The data do not reflect pre-existing conditions, multiple diagnoses or severity of illness.

- Statistics do not reflect those patients admitted with very serious illness who have "DNR" orders ("do not resuscitate").

- Hospitals whose rates were within the "predicted mortality range" should be identified and commended.

- Hospitals which conduct monthly mortality reviews as a quality control activity should be identified and commended.

I cannot overstate the importance of publishing these data with strict attention to the caveats outlined above. Again, the Health Care Financing Administration is using statistical analysis to provide an indicator on hospital-wide quality. In these challenging times, this is a dangerous construct.

Sincerely,

Herbert F. Dorsett
President

/kp

St. Anthony's Hospital
A Community of Care

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, DC 20201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for January 1, 1986 to December 31, 1986.

As a health care provider, we have a major concern regarding the overall usefulness of this information being provided to the general public. It is interesting to note that HCFA originally developed the DRG data to monitor Medicare billing, not the quality of care. In this case, a statistical tool is being used to do a job for which it was never intended. Clearly, the HCFA data cannot and should not be seen as indicative of the care patients receive during hospitalization.

Our review showed the following:

- 89.2% of the mortalities were people between the ages of 70 and 102; 61.0% of these were 80 years old and older (16.4% were over 90).
- 73% of the total cases had multiple health problems in addition to the reason for admission.
- 20.5% (101 cases) of the deaths occurred outside the hospital. Some of these deaths may have been from a condition totally unrelated to the reason why the patient was in the hospital.
- The statistics include patients admitted with terminal conditions who expected death would occur during the admission.

For 56 years St. Anthony's Hospital has maintained a tradition of quality health care administered with compassion and loving support. It is our belief that this use of mortality rates is not an appropriate measure of quality. We cannot emphasize enough our concern regarding the possible misinterpretation of this data.

Sincerely,

Daniel T. McMurray
Executive Director

DTM/rf

1200 7th Ave. North • P.O. Box 12588, St. Petersburg, Florida 33733 • (813) 825-1100
FL 206

ST. FRANCIS HOSPITAL
Office of the President
250 West 63rd Street
Miami Beach, Florida 33141
(305)868-5000

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Healthcare Financing Administration
Washington, D.C. 20201

Dear Dr. Roper,

St. Francis Hospital has received and reviewed the HCFA Mortality Data. We support the position that the public should be educated and informed to assist them in making rational choices and decisions regarding heathcare services. For this reason the process of releasing meaningful data which in turn helps to educate the public is certainly important. However, the current data which is to be released is in and of itself not a substitute for meaningful and valid statistics.

We are concerned that the information contained in the HCFA Mortality Data will be misinterpreted by the public and media as a measure of hospital quality care. This concern is based upon the fact that the data base does not adequately account for severity of illness, a prerequisite for meaningful mortality statistics.

A review of our data indicates some inconsistencies. In one case there was a miscounting of the next to last admission in 1986 as the last. This then credited a mortality which occurred in the last admission to an incorrect mortality category, and on the same patient the date of death was inaccurately recorded. Other inconsistencies include patients being listed as dead prior to their discharge date and the dates of death not listed. Also, we cannot verify a significant number of the cases discharged from St. Francis Hospital and identified as having died. These issues do not change any category, however they do underline the importance of accuracy in the initial data base.

When one addresses the issue of how patients were classified and the variation within the ranges of predicted mortalities several important points must be made. The ranges are hospital specific and reflect the markers chosen to measure the relationship of a limited set of patient characteristics to the risk of death.

Sponsored by the Franciscan Sisters of Allegany

Therefore, ranges and predicted rates may be wider or higher for some hospitals; thus intra-hospital comparisons become more difficult and less meaningful. Hospital specific case mix indexes, which relate to Diagnostic Related Groups reflect an increasing severity of illness for Medicare patients. Of interest is the fact that St. Francis Hospital has the second highest case mix index in Dade County and still was within the predicted range for all categories.

The markers used to identify and group patients reflect age, transfer from other facilities, co-morbid condition and principal diagnosis. These measures reflect information that is available from the current data system. A significant limitation of this process relates to the decision to group a particular patient into a morbidity category based upon the principal diagnosis. The principal diagnosis is defined as the reason, after study, why the patient was admitted to a hospital. The measures do not include all the co-morbid or concurrent conditions that could effect a patient's medical status, nor does it reflect the fact that within the various high and low risk categories various procedures may have been performed. For instance, patients in the low risk heart disease category may have had an open heart or valve procedure, or patients within the high risk categories may have died shortly after arrival at the emergency room. These facts indicate that unless patients are properly identified through some more appropriate index of illness the listing of the mortalities becomes meaningless.

St. Francis Hospital is located in a part of the country where there is a significant percentage of elderly patients. In fact, over 75% of our patients are Medicare patients. Our analysis of the Mortality Data indicates that: 1) 16% of all patients who died were over the age of 90; 2) 48% of the patients were between the ages of 80 and 89; and 3) 28% between the ages of 70 and 79. Thus 92% of our patients who died were over the age of 70.

The established criteria include patients who died within 30 days of discharge from the hospital. At our institution this population is significant in that it is 18.6% of all deaths. This data does not in and of itself mean anything. Patients who were terminally ill upon admission may have gone home to be with their families, or to a hospice to die, or may have died from other totally unrelated causes.

The Hospital and Medical Staff has a long and active commitment to a Quality Assurance Program. There is a process in place for reviewing by physician peer review and/or specific criteria screens for all deaths. This process relates to the much broader quality assurance program which is in place at our institution. To this end St. Francis Hospital has been and will remain committed to a Quality Assurance Program which reviews cases by accepted and established medical and national heathcare criteria.

We appreciate the opportunity to respond at this time. The issues raised are institutional specific but reflect the broader concerns that the healthcare industry has regarding the release of information which may be misinterpreted by the public and media as an indicator of overall quality care.

Sincerely,

Sister Margaret McManus, O.S.F.

Sister Margaret McManus, O.S.F.
President & Chief Executive Officer

SrMMcM:sml

2500 Harbor Boulevard / Port Charlotte, Florida 33952 / 813/625-4122

SAINT
JOSEPH
HOSPITAL

October 27, 1987

William L. Roper M.D.
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

It has always been a concern of St. Joseph Hospital to provide quality services to all persons seeking care, despite race, sex, religion or ability to pay. The emphasis on quality medical care is not a new one. For several years various federal, state and voluntary agencies have focused on hospitals' ability to provide and continual pursuit of quality healthcare services. We are proud to say we have always participated in such programs and are continually developing mechanisms to bring to light any opportunities to improve care. We welcome these HCFA Mortality statistics as yet another mechanism for review.

The quality of care provided at St. Joseph Hospital is of utmost concern to the hospital's Governing Body, Administration and Medical Staff. Each of these entities provides support to the provision and review of quality care. Indications of quality issues are promptly investigated through our Quality Assurance Program. When quality issues are identified action is taken with the necessary department or responsible person involved. Follow up activity is aimed at determining whether the action taken resolved the quality issue identified. Reports of all activities are provided to the Medical Staff, Administration and Governing Body. This mechanism has proven effective for us and was judged as being in compliance with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations. Our last JCAHO survey was September 11 & 14, 1987. The main theme of JCAHO is quality Assurance

In reviewing the mortality rates for St. Joseph Hospital to be published by HCFA, we note that we fall in line with HCFA's range of predicted mortality rates in all categories.

Review of the HCFA mortality statistics indicated the need for further investigation to refine, and clarify, by the inclusion of all existing and contributing factors related to severity of illness.

Fifty-five percent (55%) of the cases identified would not have been expected to improve. The contributing factors of advanced median age of 75.4 and the secondary diagnosis of cancer and heart or renal disease existed.

The HCFA mortality data is an initial process that when expanded upon compliments the current, on going hospital quality assurance review program that exists at St. Joseph Hospital.

Sincerely,

ST. JOSEPH HOSPITAL

Michael B. Cronin
Executive Vice President

St. Luke's Hospital

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Sir:

Please include the comments below in the December HCFA publication of selected Medicare mortality information for St. Luke's Hospital, Jacksonville, Florida:

> While we welcome HCFA's effort to assess institutional quality of care, this particular mortality-based method requires further validation before it can be considered useful. The scope for misunderstanding this data, both by consumers and professionals, is far too great and we caution anyone against using them as an index of quality.
>
> St. Luke's Hospital has established a hospital-wide Quality Assurance Program through which ongoing surveillance of patient care is conducted. Routine collection and analysis of data by professionals is coupled with an indepth review of every inpatient's care, including those who expire, using quality screens that isolate problems or unexpected outcomes. Through such a program of quality review, the hospital and medical staff have a mechanism for evaluating the quality of care delivered.
>
> St. Luke's Hospital does support the concept of developing objective measures for the public's use in assessing the quality of care of a hospital, and accordingly are pleased with HCFA's initial efforts toward this long term goal.

Thank you for the opportunity to respond.

Sincerely,

J. Larry Read

J. Larry Read
Administrator

sm

4201 Belfort Road □ Jacksonville, Florida 32216-5898 □ (904) 739-3700

St. Mary's HOSPITAL

901 - 45th Street • P.O. Box 24620 • West Palm Beach, Florida 33416-4620
Telephone 305-844-6300

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Gentlemen:

In response to Dr. William L. Roper's letter of September 21, 1987, pertaining to publishing (by HCFA) selected mortality information about all short term acute care hospitals which treated Medicare patients in 1986, we have reviewed the information provided by Dr. Roper and comment as follows.

We acknowledge and highly support the public's right to know and their ability to make informed decisions regarding their health care. The American Hospital Association and other organizations, including the Joint Commission on Accreditation of Healthcare Organizations, are investigating methods of evaluating the quality of patient care that rely on methods other than mortality rates. St. Mary's Hospital looks forward to the results of these efforts. We recognize that better methods of measuring the quality of care are needed by the public and we highly support such efforts.

If you have any questions or if we can be of any further assistance in this matter, please feel free to contact me at 305/881-2871.

Sincerely,

Sr. Patricia C. Friel, OSF

Sr. Patricia C. Friel, OSF
Administrator

SPCF/pl

Office of The President

St.Vincent's Medical Center

1800 Barrs Street
Post Office Box 2982
Jacksonville, Florida 32203
904-387-7302

October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The 1986 data provided by HCFA indicate that of 4,396 Medicare patients admitted to St. Vincent's Medical Center, there were 427 deaths, a 10% mortality rate. Three hundred forty deaths were attributed to inpatients and 87 deaths were noted as occurring after discharge. Our own investigation of 1986 records however, reveals that 79 patients died after discharge (one patient was transferred to an out-of-state acute care facility and records were thus, unattainable); 346 Medicare inpatients died within 30 days of admission; and there were 7421 Medicare admissions. Utilizing the number of Medicare admissions, the mortality rate is 5.75%.

There was not a detailed description of the data utilized by HCFA in computing predicted mortality ranges: it does appear that many significant factors were not included in the model. While we appreciate the difficult task HCFA had in attempting to assess quality in an equitable and meaningful manner, the deficiencies need to be addressed since they are significant contributory factors.

The model does not address severity of illness for the principle diagnoses or comorbidities. Severity of illness should be assessed through several avenues including, but not limited to, the patients' general medical condition upon admission; the significance and severity of comorbidities, the extent of disease processes; and patient age. The demographics of hospitals' catchment areas should also be considered.

Of the 426 patients who died, over 78% or 334 were 75 years of age or older; 58% or 247 patients were 80 years of age or older and 33.5% or 143 were 85 years of age or older.

The severity of illness or acuity should also be assessed through the mode of admission and point of origination. Of the 426 patients who died, over 62% were so ill, they required admission through the emergency room or, were transferred from another hospital or other health facility. In all cases except Pulmonary, our mortality rates are below the mid point of the range of expected mortality. It is imperative to note that of the patients attributed to that diagnosis, 80% required emergency room admissions and 83% were over the age of 80. Also of note, 100% of the patients admitted for cerebral vascular accidents and 94% of patients admitted with sepsis, were admitted through the emergency room.

As a respected tertiary care hospital, St. Vincent's Medical Center receives more than its share of emergency room to emergency room transfers from community hospitals which do not have the wherewithal to treat the seriously ill patient. In assessing demographics and hospital catchment areas one must also be aware that the incidence of severe cardiopulmonary disease is more prevalent in the quadrant of this city we serve.

The assessment of patient death after discharge statistics needs to include the condition and prognosis of the patient at the time of discharge, appropriateness of discharge utilizing HCFA screens, and the disposition of the patient. Of the 80 patients who died after discharge, over 95%, or 77 were either discharged in anticipation of death, for terminal care, or in the case of two patients, they left the hospital against medical advice. Approximately 94% or 75, of the patients were discharged to another care giver (i.e., hospice, home care, skilled nursing facility, etc.). Except for the patients that left against medical advice, discharges which we cannot control, the patients discharged from St. Vincent's Medical Center were stable, in accordance with HCFA discharge screens and thus appropriate for the discharge. It should be noted that we are unable to routinely collect information related to discharged patients who expire elsewhere. We appreciate the opportunity to review the HCFA data and would like to continue to receive this information for inclusion in our quality assurance activities.

Quality Assurance is a Medical Staff and Administration priority at St. Vincent's Medical Center. Quality Assurance activities are conducted both concurrently and retrospectively, on a monthly basis for the review and evaluation of patient care and treatment. The Medical Staff utilizes clinically valid criteria to assess the quality and appropriateness of care. Mortality and morbidity review are incorporated in the quality assurance process. Indeed the medical record of all patients who died in St. Vincent's Medical Center were reviewed and evaluated long before the HCFA statistics were released and have been reviewed again since the release.

We hope this information will prove to be useful to HCFA in the quality assessment process.

Sincerely,

Sister Mary Clare Hughes
President
St. Vincent's Medical Center

William J. Garoni Jr., M.D
President
St. Vincent's Medical Staff

VLG:vmr

St.Vincent's Medical Center

Suwannee Hospital, Inc

Suwannee Hospital, Inc. has reviewed the Medicare mortality data information published by the Health Care Financing Administration and found no substantive errors in the data.

As the data can be easily misinterpreted, it is important to note that these data, which represent a singular and simple evaluation of mortality rates for Medicare patients, do not in and of themselves represent any significant measure of quality of care.

Additionally, to the extent that any of Suwannee Hospital's data fare outside of statistical ranges established by HCFA, careful consideration must be given to certain circumstances. Among these facts is that our our hospital is frequently the major referral center for some area nursing homes when their elderly patients become so seriously ill that they are, in fact, terminal. A second consideration is that in excess of 90% of all county ambulance runs terminate at Suwannee Hospital. This would suggest that Suwannee Hospital is seeing a number of very ill patients, some of whom will not survive the condition of concern. Lastly, consideration must be given to the influence that small sample number of cases may have on the use of statistics.

As a not-for-profit community hospital, the Board of Directors, the medical staff and the employees are extremely proud of our service to the citizens of Suwannee County and surrounding areas and confident in the quality of care provided in our hospitals. To assure our patient population of our commitment to quality of service, Suwannee Hospital has in place a comprehensive quality assurance program accredited by the Joint Commission on Accreditation of Hospitals and approved by the Medicare Program. This program monitors all patients treated at our hospital to include every death occurring within the hospital. This systematic approach to the assessment of quality care results in a consistent level of quality within our institution and represents a greater measure of the quality of healthcare provided to our patients than once a year statistical sampling of mortality data.

Williston Memorial Hospital

Williston Memorial Hospital, Inc. has reviewed the Medicare mortality data information published by the Health Care Financing Administration and found no substantive errors in the data.

The Board of Directors, medical staff and employees of Williston Memorial Hospital, Inc. are pleased to see that all of the mortality rates for our hospital are well within the ranges set by the Health Care Financing Administration. We recognize that the preservation of our standard of quality will be based on our systematic approach to the assessment of quality within our institution rather than the study of one variable which can change dramatically from year to year through simple statistical variations.

As a not-for-profit community hospital, we are proud of the services we provide to the citizens of Levy County and surrounding areas and confident of our quality of care.

To best assure our patient population of our commitment to quality of service, Williston Memorial Hospital has in place a comprehensive quality assurance monitoring program accredited by the Joint Commission on Accreditation of Hospitals. Our quality assurance program monitors all patients treated by the hospital, including a review of every death occurring within the hospital. Staff physicians screen quality indicators on a regular basis as a means to evaluate the care provided to our patients. This systematic approach to the assessment of quality care results in a consistent level of quality within the hospital. The singular and simple evaluation of mortality data as the only assessment of quality is considered to be inappropriate since such mortality rates may fluctuate considerably from one period to another for any particular hospital.

A member of Santa Fe Healthcare Systems

P.O. Drawer 550 / Williston, FL 32696 / (904) 528-2801

HCA Tallahassee Community Hospital

October 22, 1987

Health Care Financing Administration
Health Standards and Quality Review
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: 1986 Mortality Data for Medicare Patients
HOSPITAL ID NUMBER: 100254

Dear Sir or Madam:

This constitutes HCA Tallahassee Community Hospital's official response to 1986 mortality data for Medicare patients as compiled by the Health Care Financing Administration.

Of Tallahassee Community Hospital's 1,053 Medicare cases, 122 deaths occurred representing an approximate 12 percent mortality rate. Ninety-five (95) patients died within the hospital. Twenty-seven (27) patients (22 percent of total deaths) apparently died outside of the hospital within 30 days of discharge. Tallahassee Community Hospital respects the personal and private side of death and did not seek to confirm deaths with family members of those patients who did not die in the hospital.

Sixteen deaths (13.2 percent of total deaths) occurred within 48 hours of admission to the hospital. The median age of Medicare patients considered by this report was 79.

This report assumes that the principle diagnosis was the cause of death. This is not necessarily true. There were 25 patients (26 percent of deaths occurring in the hospital) where the principle diagnosis was not the cause of death. Tallahassee Community Hospital believes it would be more appropriate to cite the cause of death versus the principle diagnosis.

All deaths, regardless of age, are screened by the hospital's Quality Management Services Department. Such cases are then sent for further review to the department in which the attending physician is a member.

Sincerely,

Nick Carbone
Administrator

2626 Capital Medical Boulevard
Tallahassee, Florida 32308
Telephone (904) 656-5000
A subsidiary of HCA The Healthcare Company

TALLAHASSEE MEMORIAL REGIONAL MEDICAL CENTER, INC.
MAGNOLIA DRIVE AND MICCOSUKEE ROAD • TALLAHASSEE, FLORIDA 32308 • (904) 681-5385
(a non-profit corporation)

M. T. Mustian, FACHA
President/Chief Executive Officer

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

RE: Tallahassee Memorial Regional Medical Center, Inc.
Provider Number 10-0135

Dear Dr. Roper:

The mortality information reported by HCFA for Tallahassee Memorial shows that the hospital has excellent experiences in patient care. The majority of the Medical Center's mortality percentages were on the low end of the predicted range for the disease categories presented by HCFA.

The Medical Center's strong showing is all the more important because of its mission in the community as the tertiary hospital for a 16-county region. As the premier referral center for the area, Tallahassee Memorial becomes the receiving institution for those seeking care at a level no other hospital in our area can provide. Tallahassee Memorial receives more than 40% of its patients from outside of Leon County. In some cases, death is not an unexpected outcome for a patient. This is particularly true with terminally ill cancer patients in our extensive cancer program. These results are also impressive considering that Tallahassee Memorial has the highest level of acutely ill patients in the area.

Quality of patient care is important to the Medical Center. It has placed a high priority on quality assurance with experienced staff nurses and physicians reviewing medical cases to ensure quality care.

Despite its excellent results in the HCFA data, Tallahassee Memorial has concern relative to several aspects of the data released: 1) HCFA's definition of cases to be included in the study, 2) discrepancies between HCFA data and Medical Center data and 3) interpretation of the mortality information.

The summary statistics prepared by HCFA for Tallahassee Memorial indicate 4,250 total Medicare cases for calendar year 1987. The Medical Center's records show more than 7,000 Medicare cases. The discrepancy results because HCFA excludes from its totals all but the last admission for any patient with multiple admissions during the year. This has the effect of significantly overstating the true death rate for Medicare admissions.

The Medical Center applied the HCFA definitions and methodology to its own data base in order to verify HCFA's results. While HCFA reported 4,250 total Medicare cases, the Medical Center identified 4,933 Medicare cases meeting HCFA's definition for inclusion in the statistics -- a difference of 683 cases or 14%. These missing cases have a significant effect on the true mortality rates for the individual disease categories. For example, the Medical Center's data included 10 more cases in the category for sepsis. HCFA's data shows the Medical Center exceeds the predicted range of mortality for this category. However, with the addition of the omitted cases, the Medical Center's mortality rate falls within the predicted range. Since the detail data provided to the Medical Center by HCFA listed only those patients who died, the Medical Center was unable to determine the reasons for HCFA's exclusion of 683 cases.

Interpreting mortality rates must be done with the understanding that deaths are categorized by primary diagnosis of the final admission for a particular period of time. Patients frequently have multiple medical conditions which may contribute to the cause of death, but are not reflected in the final admitting diagnosis. The data provided by HCFA is intended to identify differences between a hospital's mortality experience and a predicted average so that substantial problems can be further reviewed. A death rate above the predicted range may not by itself indicate a problem in the delivery of care. At Tallahassee Memorial, sepsis was the only area where the mortality rate reported by HCFA was above the predicted range. Consequently, all of the cases were subjected to careful review by members of the medical staff. The mean age of these cases exceeded 81 and each patient had serious associated medical problems, including associated malignancy in eight; dementia in seven; immunosuppression in 12. All of the 28 patients were determined to be terminal or near terminal at the time of admission. Peer review determined that the sepsis death cases involved the frail and elderly. Treatment was found to be appropriate in all, and the probability of death could have been predicted in all cases on admission. As indicated above, the Medical Center's actual mortality rate including cases omitted in the HCFA data was within the HCFA predicted range.

The HCFA data also includes patients who died within 30 days after hospital admission, whether or not the patient was in the hospital at the time of death. Such a death may have resulted from circumstances unrelated to the hospital stay.

Tallahassee Memorial's role as a regional medical center attracts a significant number of severely ill or injured patients. Overall, hospitals such as Tallahassee Memorial which specialize in providing heart, cancer and trauma care for the entire region can expect higher mortality rates than the average community hospital. We feel the HCFA data is a confirmation of the high standards of quality care provided by our professional staff.

Sincerely,

M. T. Mustian

BEACHES HOSPITAL

25 Years of Dedicated Service

1430 16th Avenue South Jacksonville Beach, FL 32250 (904) 246-6731

October 28, 1987

TO WHOM IT MAY CONCERN

Healthcare Financing Administration Health Standards and Quality Bureau

This letter is in response to the advanced mortality information generated by the Healthcare Financing Administration which is planned to be released in December of 1987. The purpose of this response from this hospital is to provide comment on the specific information as it pertains to this hospital. Our Medicare identification number is 10-0117. We appreciate having the opportunity to comment in advance of the release of the information.

First and foremost, it must be pointed out and emphatically emphasized that the general public can not interpret quality of care based on the mortality information which will be published in this report. There are many significant reasons for this fact, the most glaring of which is the fact that there is no severity of illness attached to any of the information on these patients.

We all know hospitals are not identical in nature, however attempts to publicly publicize a minute portion of hospital operations is definitely overemphasizing the publics ability to interpret such data. Death is an expected result in many admissions to hospitals. The information gives no assistance in determining whether a patient was admitted to the hospital in complete health with one minor problem, or simply placed in the facility as an appropriate location to spend their last days. Many patients of this age and illness group are terminally ill patients transferred from nursing homes to the hospital or some are even "no code" patients when they arrive at the hospital. In the smaller facility there is even no way to determine whether or not the patients admitted to their facility were admitted for appropriate treatment or were again admitted to spend their remaining days, thus giving a very distorted and misleading image when reviewing the mortality information. Small numbers can greatly distort the percentages being reviewed. Also, when considering the Medicare information the public can gather a greatly distorted view of the overall impressions of the quality of care in the hospital due to focusing in on that mix of patients only. Also, the geographic area in which the hospital is located and the age of the population in which that area hospital is located can have a significant effect on the mortality information.

continued

Quality of care is a great issue at all hospitals across the nation. The Joint Commission on Accreditation of Hospitals is a benchmark which all hospitals can be judged. To provide bits and pieces of information to the general public allowing for them to make their own decisions regarding quality of care, when detailed monitoring techniques are available in all hospitals that are Joint Commission accredited, can provide a false comfort level to the average person.

We sincerely appreciate having the opportunity to review this information from a providers' perspective. It is equally appreciated to be able to comment regarding this information. However, it is extremely frustrating to be categorized on inappropriate, unbiased and misleading information, and until such time as an acceptable and accurate method can be utilized to review the quality of all patients in all hospitals, such information should be maintained within the professional ranks of hospitals and they should be allowed to continue the pursuit of quality of care to the various respected programs.

Sincerely,

Bart Hove

Bart Hove
Administrator

BH/sc

AMI Town & Country Medical Center

October 29, 1987

William L. Roher, M.D.
Department of Health & Human Services
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roher:

Thank you for giving us the opportunity to provide input on the mortality statistics for the period between January 1, 1986 and December 31, 1986.

Our hospital medical staff committees monitor every death in our facility as part of our concurrent Quality Assurance Program. We believe that our monitoring system provides us with an effective method of meeting and exceeding quality care standards.

All of our mortality rates fell within the range of predicted mortality rates and all dates of death match our records except for those who expired after discharge.

Sincerely,

Larry E. Hanan

Larry E. Hanan
Executive Director

LEH:la

cc: John J. Silver, Jr.
Deborah Green

6001 Webb Road, Tampa, Florida 33615-3291 813 885-6666

University
General
Hospital

FEDERAL EXPRESS

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
200 Independence Avenue S.W.
Washington, DC 20201

RE: UNIVERSITY GENERAL HOSPITAL
PROVIDER NUMBER 10-0235

Dear Dr. Roper:

In response to your letter of September 21, 1987, I have reviewed the information about Medicare experience at University General Hospital for 1986 and, by this letter, submit our comments and corrections of the data, as indicated on the attached patient listing initially sent to us by HCFA, for the December publication.

The data used by HCFA indicates that a total of one hundred, thirty-one (131) Medicare patients admitted to University General Hospital died within thirty (30) days of their last hospital admission in 1986. Of these, one hundred and seven (107) died while still a patient in the hospital, and twenty-four (24) died after hospital discharge.

It is reported by HCFA that the total number of Medicare beneficiaries whose last admission to University General Hospital was one thousand, sixty-nine (1,069). Our records, however, indicate a total of one thousand, seven hundred and eighty-four (1,784) Medicare admissions in 1986. Presumably, this discrepancy reflects multiple admissions of individual Medicare patients to this Hospital. Our own records indicate, however, that of one hundred, thirty-one (131) Medicare patients who died within thirty (30) days of their last admission while still an inpatient, twenty-three (23) were still alive at the time of discharge. Due to the lack of readily available information, it is difficult to determine the outcome of those patients who were discharged alive but reported as having died. Although information concerning death after discharge is not included in the patient's medical record, a review of individual patient charts, discharge summaries and physician progress notes indicated that these patients had either a terminal condition or a poor prognosis.

In view of University General Hospital's mortality rates compared to the Range of Predicted Mortality Rates, we were at or below the mean mortality rate in all cases except in three (3) of the high risk categories: 1) cerebrovascular accidents, 2) sepsis, and 3) severe chronic heart disease. For each of these categories, however, we were above the mean value in the range but still within the upper end of each range.

10200 Seminole Boulevard Seminole, Florida 33544 813/397-5511

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Patients with cerebrovascular accidents (stroke) were medically compromised upon admission with large or massive cerebral hemorrages, infarcts, or were comatose. In each of these cases, death was an expected outcome or significant possibility. Under the diagnostic category of sepsis, all patients were admitted in spetic shock or had extreme elevations of their white blood cell count. In each of these cases, death was an expected outcome. Patients with severe chronic heart disease were admitted with an acute episode of congestive heart failure progressing into acute respiratory failure and multi-system failure despite agressive medical attention. These high risk categories represent patients who were severely medically compromised upon admission to University General Hospital.

While HCFA's efforts to improve the measurement of health care quality provided by hospitals nationwide is a worthwhile and valiant effort, decisions regarding the quality of care provided to individuals can only be made after careful review of the patient's medical record. Future efforts to refine the model should include the patient's general health status, the stage of the patient's illness and the patient's psychologic condition. Statistical analysis of hospital mortality data can do no more than screen for further quality of care review at the individual hospital level. The HCFA data will likely identify trends and patterns among hospitals that can legitimately be answered only by detailed review of the patient's medical record. Despite its limiata-tions, HCFA's information may prove valuable in further developing a more valid and reliable scheme to measure quality of patient care.

Thank you for allowing us the opportunity to comment on this information. Should you have any questions or require additional information, please do not hesitate to contact me.

Sincerely.

Frank W. Harris

Frank W. Harris
Administrator

FWH/kjf

Attachments (6)

October 22, 1987

UNIVERSITY HOSPITAL
OF JACKSONVILLE
655 West Eighth Street
Jacksonville, Florida 32209
Telephone 904-350-6899

John F. Gregg
President

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Provider #10-0001

Dear Dr. Roper:

We are in receipt of the mortality information about Medicare patients treated in our hospital in 1986 and appreciate the opportunity for review prior to publication.

Our major concern is that mortality statistics do not accurately reflect quality of care. For example, our hospital is a designated Level I (full service) trauma center with a high volume Emergency Department. We have a hospital based helicopter service transporting patients to us from local and outlying areas. We are a teaching hospital with numerous specialties and subspecialty services and are contracted to care for the indigent in the county. Each of these factors indicate our treatment of high risk patients and can influence the mortality rate. In addition, severity of illness is an aspect which impacts the mortality rate. Since these factors have not been included in the development of the mortality rates, the statistics are not a complete measure of quality.

Our mortality rates fall well within the predicted range in all diagnostic categories, however, the total number of cases reviewed was approximately 63% of our actual Medicare admissions. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals based on the methods used to determine the rate.

We realize that each hospital uses different identifiers for patient information, but we ask that you add the patient control number from the UB-82 to the information you send out to hospitals. We were unable to identify several patients because they were not listed on our census for the admission or discharge date. Our system does not allow us to use the HIC number and the limited letters of the name did not prove to be a successful method to identify these particular patients. Therefore, it is difficult to verify our data completely.

We ask that you consider these comments in further mortality rate development. Again, we thank you for the opportunity to review and comment on the data.

Sincerely,

Mary A. Johnston, R.N.

Mary A. Johnston, R.N.
DRG Coordinator

An Equal Opportunity
Affirmative Action Employer

UNIVERSITY OF Miami

UNIVERSITY OF MIAMI HOSPITAL & CLINICS
NATIONAL CHILDREN'S CARDIAC HOSPITAL

1475 N.W. 12th Avenue • P.O. Box 016217 • Miami, Florida 33101
Telephone (305) 547-6418

COMMENTS ON THE HCFA MORTALITY DATA
UNIVERSITY OF MIAMI HOSPITAL & CLINICS
MIAMI, FLORIDA

Medicare Provider Number 10-0079 October 19,1987

DATA VERIFICATION

The University of Miami's data indicate the following:

January 1, 1986 - December 31, 1986

Total Medicare admissions	606
Total Medicare expirations in hospital within 30 days of last hospital admission	26
Total Medicare expirations out of hospital within 30 days of last hospital admission	1

There was a total of twenty-eight (28) expirations listed in the HCFA data. The hospital can verify information on twenty-seven (27) of these.

The HCFA data listed four (4) expirations out of hospital within 30 days of last hospital admission. The hospital records indicate only one (1). Two (2) of the expirations took place in the hospital on admissions not noted in the HCFA data. The one (1) other expiration listed by HCFA involved a patient for whom the hospital has no record of ever being admitted.

SPECIAL AND INTERPRETIVE REMARKS

The University of Miami Hospital & Clinics is a specialty hospital with a number of critically ill patients referred for care from the south Florida region. Many patients have chronic illnesses with poor prognoses and for whom death is a significant possibility and expected outcome.

Most expirations were of patients who had been treated over relatively long periods of time by hospital physicians. At least fifteen (15) patients were in this category; there were eleven (11) other patients seen on direct referral from area hospitals. Expiration occurred on the first admission for one (1) patient who was not referred.

There were eleven diagnostic categories listed by HCFA. The hospital was within or below the predicted mortality range in ten (10) of these. The hospital's mortality rate falls outside of the range in only one (1) of the predicted mortality rates. This involved one (1) patient who died of cardiac arrest on the day of admission after being referred from another hospital for treatment of a non-cardiac condition.

Venice Hospital

540 The Rialto • Venice, FL 33595-3298 • (813) 485-7711

When examining the Health Care Financing Administration's mortality statistics for any hospital, no matter how positive they appear, it is important to remember that mortality is but one of a number of measures of the quality of care that an institution provides. Also, the method of calculating the mortality rates continues to be modified, and has been subject to widespread disagreement in the medical industry as to its validity.

Venice Hospital has in place an effective Quality Assurance program which examines many quality indicators. This program has contributed to the hospital receiving its reaccreditation from the Joint Commission on Accreditation of Hospitals without contingencies. Only approximately 10 percent of the over 5,000 American hospitals which receive JCAH accreditation can claim this distinction.

Persons seeking further information are recommended to contact the Venice Hospital Public Relations department, 540 The Rialto, Venice, FL 34285-3298, (813) 485-7711, extension 1121.

Provider Number 100070

An Affiliate of Gulf Area Medical Programs.
"Building a System of Health Care Services."

William L. Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: Provider #10-0275

Dear Dr. Roper:

Thank you for your cover letter of September 21, 1987 and attached hospital mortality statistics for the Wellington Regional Medical Center.

In reviewing the mortalities for the period in question, the following observations must be made:

1. As mentioned in page three (3) of your communication the publication of mortality statistics does not act as a measure of the quality of any individual hospital. Yet, the publication of mortality statistics may impede the publics understanding of any hospital's operations and may impede the success of quality assurance mechanisms already in place in most institutions. Specifically, the public will not be given important information regarding the patient's severity of illness, progression of that illness and/or expected outcome (which could include the patient's death). It is imperative that in the study of mortalities the patient's unique psycho-social as well as physiological background be taken into account. As any subtle change in the patient's total homeostasis can have a bearing on life expectancy and death, additional factors must be considered prior to the publication of mortality statistics.

2. As any deviation from the projected mortality rates could cause concern regarding an individual institutions ability to provide quality care, the public must be admonished that the publication of such mortality statictics fail to include important sociological demographics and although the deaths at the Wellington Regional Medical Center fell well within the predicated range rates, it must be recognized that while patients in South Florida will present with high risk illness as the principal diagnosis, the secondary diagnosis may present an even higher risk and may contain the important elements of the end-stage severity.

3. In review of the Wellington Regional Medical Center mortalities the following must be noted:

[redacted] the patient's diagnostic catagory is listed as ME, metabolic disorder, with an appropriate principal diagnosis of dehydration. Despite that fact this in itself represents a high risk diagnosis, other important information regarding the secondary diagnosis of metastic carcinoma of the colon to lung and liver, Stage IV would not be depicted in statistical publication.

A second example would certainly be Patient [redacted] in low risk diagnostic catagory GU with a principal diagnosis of renal failure. The statistical data would not include such important information as secondary diagnosis of urosepsis with dehydration and multiple decubitus ulcers. It would be important to note that this patient was both a nursing home patient of long duration

and was a "Do Not Resusitate" candidate. The patient's prognosis was poor and death was expected.

Finally, as regards patient [redacted] with the low risk diagnostic catagory of GU, the patient was discharged from the hospital with the principal diagnosis of acute urinary tract infection, was ninety two years of age (92) and was also a nursing home resident. In this case the patient's second admission to Wellington Regional Medical Center was not properly displayed on the HCFA printout with the second admission date actually 1-10-87 with date of death 1-12-87 due to unsuccessful cardiac resusitation.

4. The above information would lead to another important consideration. Has the data provided to hospitals been properly validated and has proper response time been allocated to hospital to review the mortality information and respond appropriately? In this regard, it is questionable as to whether the mortality rates projected for this hospital could be used as an accurate measure for any statistical projection for death rate comparisons with other hospitals. Such hospitals may have dissimilar patient outcome expectations and/or social-economic factors that may effect patient death rates.

It is our sincere hope that you will continue to refine your analytical methodology and validation techniques to include the important considerations as outlined above. This response is presented to you in all fairness to both the hospital providers and the patient population we serve.

Sincerely,

Arnold R. Schaffer
Managing Director

HCFA10B7

WEST BOCA MEDICAL CENTER

October 26, 1987

William Roper, M.D.
Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: MEDICARE MORTALITY STATISTICS FOR MEDICARE PROVIDER #100268

Dear Dr. Roper:

The Medicare mortality statistics compiled for calendar year 1986 by HCFA concurs with hospital generated statistics. The hospital places tremendous efforts in ensuring quality care and your figures substantiate these efforts. 59% (10 of 17) of diagnostic categories listed had an actual mortality rate that was less than or equal to the low end point of the range of predicted mortality rates for those categories. The remaining seven categories (41%) demonstrates that the hospital had mortality rates that did not exceed the mid point of the range. It is our belief that these impressive statistics are the result of a very aggressive and proactive quality assurance and utilization review program.

Given the above performance, the hospital focused its review efforts on those deaths that took place post discharge. A total of 17 patients expired following discharge within 30 days of their discharge date. The reasons for these deaths were as follows: two patients had metastatic cancer and refused further treatment; five patients had endstage chronic heart disease; two patients died of endstage chronic pulmonary disease; four patients had cerebral vascular accidents with complications including pneumonia; two patients had sepsis with multiple medical problems; one patient, a 94 year old, was discharged after deep vein thrombosis was ruled out and expired in his sleep at a nursing home; and, the last patient died of unknown origins. To summarize the 17 cases, 16 of them had disease processes of an advance chronic nature and death was inevitable.

It is very important for the public to know that hospitals are subject to a very critical check and balance system aimed at ensuring the appropriate delivery of health care. As mentioned, the hospital has a very aggressive internal assessment program via its Quality Assurance and Utilization Review committees. All deaths occuring within the hospital are reviewed by physician members of these designated committees.

Externally, the hospital is responsible for reporting its quality assurance program to three separate entities. First, the hospital is reviewed on an annual basis by state and county health care departments in order to maintain an operating license. Failure on the hospital's part to meet quality standards will result in closure of its operations. Second, the Joint Commission on the Accreditation of Hospitals, a private non profit organization of health care professionals, reviews the hospital's quality assurance activities every three years. This certification is prized by every hospital facility as it demonstrates the hospital's ability to provide excellence in quality health care. Finally, the Professional Review Organization (PRO), is the federal "watch dog" mandated by law to assure that the hospital is ensuring that the health care delivered to its patients is necessary and appropriate.

The hospital appreciates HCFA's courtesy in extending to us the opportunity to explain its mortality statistics for calendar year 1986. It is the hospitals hope that these statistics as well as this response will demonstrate to the people it serves in its community that it is a provider of high quality care.

Sincerely,

Barry G. Weinbaum,
Administrator

BGW/lkk

HCA West Florida Regional Medical Center

West Florida Hospital
The Pavilion
Rehabilitation Institute of West Florida

October 21, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

It is our understanding that the Health Care Financing Administration plans to publish selected mortality information about all short-term acute care hospitals which treated Medicare patients in 1986.

West Florida Regional Medical Center, Pensacola, Florida has reviewed the attached HCFA/Medicare mortality data as a part of our on-going comprehensive medical staff peer review system. Mortality review is performed in order to assure that our patients receive high quality, cost-effective health care at our facility.

Thank you for the opportunity to review the Medicare mortality information, prior to the publication of this information in December 1987.

We have verified the HCFA data, analyzed it, and would like to submit the following written comments:

1. Lack of Classification of Patient's Severity of Illness at Admission: Variations from hospital to hospital in the severity of patient illness at the time of admission are not very well recognized in the HCFA analysis. Thus, hospitals which typically receive the sickest patients may inappropriately appear to have higher mortality rates in the Medicare analysis. It is our understanding that HCFA recognizes this major technical flaw in the study and HCFA will acknowledge this fact in its discussion of the data.

8383 North Davis Highway
Post Office Box 18900
Pensacola, Florida 32523-8900
Telephone (904) 478-4460
A subsidiary of HCA The Healthcare Company

West Florida Regional Medical Center is a 547 bed acute care hospital which has a large referral pattern which includes southeast Alabama and northwest Florida. Patients are referred from outlying physician offices and hospitals which do not have sophisticated diagnostic or treatment facilities nor the physician specialists to provide appropriate care. Special services provided at West Florida Regional Medical Center include a Cardiac Center including Open Heart Surgery, Certified Cancer Treatment Center, Neurology/Neurosurgery Center including a designated Spinal Cord Injury Center, and a Level II Trauma Center. These are specialties in which one would expect an increase incidence of deaths due to either a life-threatening event or chronic debilitating progression of an illness. For this reason, it is unrealistic to attempt to measure a hospital's performance by HCFA mortality statistics since these statistics do not give any consideration to the various populations being served by the different hospitals.

2. Errors in the HCFA Raw Data: West Florida Regional Medical Center would like to identify and correct the following errors in the data used by HCFA in this analysis:

   Significant errors in the post-discharge death data, which has resulted in an erroneously high mortality rate: In review of the medical records of the post-discharge deaths, 9 out of the 46 patient deaths which HCFA recorded as occurring post-hospitalization actually occurred last day of the hospitalization. This is a 20% error rate. In review of these deaths, the patients were expected to die from their long-standing terminal illness.

   Two of the 46 post discharge deaths were erroneously attributed to West Florida Regional Medical Center. In review of the medical records, these patients had been transferred to a military hospital as required by their health insurance for their continued care.

Post-discharge Deaths: Nursing Home Setting: Of the 16 deaths which occurred in a post-acute care facility, such as a community nursing home or inpatient hospice, 3 of these 16 deaths or 19% were incorrectly reported as to the date of death. In this category of chronically ill patients with pre-terminal or terminal illnesses, the patients were appropriately placed in an alternate care setting consistent with HCFA guidelines. All of these patients were provided discharge planning services and progressed to a non-acute health care facility appropriate to their care needs when their condition was stable and it was no longer medically necessary for the patient to remain in the hospital.

HCFA's concept of a continuum of care can be described as progressing the patient to the most cost-effective level of care in order to maximize appropriate utilization of the most cost-effective facility or services capable of meeting the patient's care needs, which will ultimately reduce Medicare health care cost. This Medicare utilization control is monitored extensively on an ongoing basis by the state PRO's in order to assure compliance. If the PRO's determine on retrospective chart review that the care could have been provided in a less costly setting, payment will be denied retrospectively to the hospital after services were rendered in good faith.

Post Discharge Deaths: Home Heath Care: Ten post-discharge deaths were chronically pre-terminal or terminally ill patients who were discharged to home care at the choice of the patient and/or family member (primary care taker of the patient). In all of these cases, appropriate discharge planning was provided by the hospital. Of these cases, 1 out of the 10 post-discharge deaths or 10% were incorrectly reported as to the correct date of death.

3. Other Minor Data Discrepancies: Other minor data discrepancies included wrong listing of patient's sex, age, or differences in the procedure codes used by the hospital versus the HCFA report.

4. Questionable Validity of Diagnostic Categories for Cause of Death: In review of the medical record, the patients did not die from the principal diagnosis as listed on the HCFA study. For example, a patient admitted under the pneumonia diagnostic category had died from severe chronic cardiac disease. Another example would be the terminally ill cancer patient who was admitted to the hospital for treatment of his pneumonia but expired because of his malignancy. The data base will forever show him as a pneumonia victim and pneumonia being the cause of death.

   The HCFA/Medicare mortality data only shows why the patient was admitted to the hospital, not why the patient died. In a sample review of the cases included in this study, the patients did in fact die from severe chronic pre-existing medical problems which makes the rate of death by diagnostic categories in this report erroneous.

   In addition, the HCFA mortality study does not include the fact that in many cases patients and family members of patients admitted to the hospital in the final stages of illness often ask that no heroic actions be taken to prolong life. But, the patient still needs hospitalization because the family can no longer handle the patient at this point on the health care continuum.

In summary, the above error rates in the HCFA/Medicare Mortality Data cast serious doubt on the validity and reliability of the findings of this study.

Sincerely,

John Kausch
Administrator

bp

WINTER PARK
MEMORIAL
HOSPITAL

"WHERE THE PATIENT COMES FIRST"

200 NORTH LAKEMONT AVENUE
WINTER PARK, FLORIDA 32792
TELEPHONE (305) 646-7000

October 27, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Healthcare Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

We have reviewed the mortality data submitted by Health Care Financing Administration and believe that such submission to the general public will serve no useful purpose. The release of such data will only serve to confuse the public and falsely raise their apprehensions regarding their potential hospital admission. In no way can the data be an indicator of the quality of care at any hospital, and we believe that the information that follows will serve to prove our assertion.

At our hospital, you reported a total of 3,180 Medicare cases when, in fact, our records indicate 4,896 Medicare admissions for the year. We recognize that for your purposes, you only counted the patient's last admission; however, to the general public, this data would indicate a mortality rate on each admission equal to 10% when, in fact, the mortality rate would only equate to 7%. This type of distortion would seem to carry through in each of the diagnostic categories listed. In addition, when you remove the 77 patients that died after discharge, our inpatient mortality rate is only 4.9%.

It should be noted that at Winter Park Memorial Hospital the median age of the deaths listed was 82 years, an age that is considered to be in a very old category. In each of the deaths listed for Winter Park Memorial Hospital, the patient had diagnoses other than the principal diagnosis listed. As you are aware, the term "principal diagnosis" is the principal reason for admission to the hospital and not necessarily the diagnosis contributing to death. As a matter of fact, all 320 of the deceased patients had more than one diagnosis contributing to their death.

For all the reasons indicated above, we do not believe that it serves the public's interest in releasing such raw data. Until such items as severity of illness and contributing diagnosis can be properly noted in your statistics, the raw data is useful only for further hospital and medical staff study.

Sincerely,

Willard E. Wisler
PRESIDENT

WEW/hs

Georgia

GA-1

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
AMI GRIFFIN SPALDING HOSP GRIFFIN GA 30223	GA-15	1378	14	9-16	61	30	14-38	78	40	19-41	46	13	9-33	77	16	13-32	68	53	25-49	38	24	6-33	162	15	11-25
APPLING GENERAL HOSP BAXLEY GA 31513	GA-16	282	20	10-20	8	63	10-68	6	17	7-72	6	17	1-63	10	40	6-56	19	63	20-62	13	31	8-54	57	23	12-34
ATHENS REGIONAL MEDICAL CE ATHENS GA 30613	GA-17	2291	13	9-16	213	33	21-38	80	26	19-40	21	5	5-39	96	25	15-32	92	41	26-47	55	42	15-41	169	17	13-27
ATLANTA HOSP ATLANTA GA 30365	GA-18 *	184	2	1-10	2	50	2-90	1	0	0-97	1	0	0-97	2	0	0-90	.	.		1	0	0-98	2	0	0-91
BACON CO HOSP ALMA GA 31510	GA-19	280	12	8-18	8	63	9-68	5	40	6-75	9	0	1-51	17	12	6-44	15	47	21-67	8	25	7-64	40	20	11-37
BALDWIN CO HOSP MILLEDGEVILLE GA 31061	GA-20	840	10	8-15	29	28	12-45	31	35	16-48	23	13	4-36	42	17	10-35	30	50	22-57	23	17	6-40	105	10	11-28
BANKS-JACKSON-COMMERCE HOS COMMERCE GA 30529	GA-21 *	433	13	8-17	13	54	13-62	8	50	9-67	8	38	4-59	20	30	7-43	13	77	21-71	31	6	8-38	80	16	10-29
BARROW MEDICAL CENTER WINDER GA 30680	GA-22	499	15	9-17	16	69	17-63	16	38	11-54	7	14	1-59	27	30	11-44	16	75	19-65	18	11	3-40	100	15	12-29
BERRIEN CO HOSP NASHVILLE GA 31639	GA-23 *	426	9	8-16	10	60	18-73	9	11	8-63	10	0	2-50	18	6	9-47	13	38	18-67	15	7	3-43	80	11	9-28
BLECKLEY CO HOSP COCHRAN GA 31014	GA-24	256	10	8-18	2	100	1-89	8	38	8-65	2	50	7-96	18	33	8-46	1	0	3-99	17	18	8-49	47	11	10-34
BOWDON AREA HOSP BOWDON GA 30108	GA-25	258	11	7-16	14	50	12-58	10	40	11-64	2	50	1-89	10	50	6-55	9	56	16-73	4	0	1-74	31	13	5-32
BROOKS CO HOSP QUITMAN GA 31643	GA-26 *	221	20	8-19	7	71	10-72	10	40	9-61	6	33	1-63	15	53	9-51	7	57	12-74	9	11	4-56	24	29	8-41
BULLOCH CO HOSP STATESBORO GA 30458	GA-27	1159	12	7-14	47	15	8-33	36	36	18-48	23	4	5-38	64	25	13-34	37	35	21-52	44	23	8-35	111	21	11-28
BURKE CO HOSP WAYNESBORO GA 30830	GA-28	324	12	8-17	5	80	8-77	22	18	12-49	6	33	4-67	26	23	11-43	7	14	10-71	13	8	4-48	42	12	7-32
CALHOUN MEMORIAL HOSP ARLINGTON GA 31713	GA-29 *	245	9	12-23	7	86	17-80	18	6	15-57	6	17	2-64	18	6	10-49	10	50	21-77	7	0	4-62	49	6	11-34
CANDLER CO HOSP METTER GA 30439	GA-30 *	352	17	9-19	8	88	22-83	16	50	14-58	8	0	2-55	19	37	11-50	14	29	18-66	9	22	2-54	53	34	12-35
CANDLER GENERAL HOSP SAVANNAH GA 31401	GA-31	3078	10	9-15	207	21	16-32	182	14	21-36	77	16	8-28	183	19	16-29	73	34	28-52	72	18	10-32	222	17	13-26
CHARLTON MEMORIAL HOSP FOLKSTON GA 31537	GA-32 *	232	10	8-18	8	63	6-62	7	29	9-71	8	25	3-57	15	7	6-46	7	14	15-78	12	25	4-50	25	8	4-33
CHARTER NORTHSIDE HOSPITAL MACON GA 31210	GA-33 *	722	12	7-14	23	43	6-40	27	19	13-47	17	24	6-44	33	21	11-39	16	44	15-59	19	32	6-44	85	21	11-29
CHATTOOGA CO HOSP SUMMERVILLE GA 30747	GA-34	242	20	9-20	11	91	6-56	10	40	10-62	3	67	1-81	14	29	8-52	16	38	17-62	15	20	7-50	30	17	5-32
CLAY CO FT GAINES HOSP FORT GAINES GA 31751	GA-35 *	125	12	8-22	1	100	1-97	11	27	9-59	.	.		12	17	5-50	7	43	14-77	8	25	2-56	10	10	7-59
CLAYTON GENERAL HOSP- RIVERDALE GA 30274	GA-36	2122	11	8-14	126	27	18-37	75	17	16-37	53	9	8-30	75	25	12-31	86	36	26-48	46	15	9-36	184	18	12-25
CLINCH MEM HOSP HOMERVILLE GA 31634	GA-37	229	10	7-18	1	100	0-97	6	33	6-70	3	0	0-83	9	0	3-53	16	0	16-61	6	33	6-70	30	10	9-39
COBB HOSP AUSTELL GA 30001	GA-38 *	1893	12	8-15	113	31	16-36	54	31	17-42	29	14	5-34	102	15	14-31	59	32	27-52	39	15	8-35	179	20	13-27
COBB MEMORIAL HOSP ROYSTON GA 30662	GA-39 *	700	13	9-17	32	63	20-54	30	43	16-48	22	14	5-39	25	32	8-39	25	28	21-59	31	6	9-41	88	14	10-27
COFFEE REGIONAL HOSPITAL DOUGLAS GA 31533	GA-40	730	12	9-16	31	42	12-44	23	43	16-54	14	21	2-42	26	8	8-39	27	70	24-61	28	7	5-36	86	21	14-34

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
Name/ Location	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
AMI GRIFFIN SPALDING HOSP GRIFFIN GA 30223	22	32	9-50	21	29	14-55	48	6	2-20	.	.		165	7	2-10	92	3	2-14	17	0	0-100	102	7	1-10	31	0	0-31
APPLING GENERAL HOSP BAXLEY GA 31513	1	0	1-97	2	50	7-95	.	.		.	.		24	4	1-25	5	0	0-82	1	0	0-100	34	3	1-20	5	0	0-94
ATHENS REGIONAL MEDICAL CE ATHENS GA 30613	16	19	9-55	10	70	10-64	74	7	5-21	4	0	0-100	197	2	3-11	91	1	1-13	20	0	0-32	171	5	2-9	128	2	0-7
ATLANTA HOSP ATLANTA GA 30365	1	0	0-100	.			.	.		13	0	0-91	5	0	0-87	12	0	0-47	.	.		7	0	0-81	74	0	0-18
BACON CO HOSP ALMA GA 31510	1	0	0-98	3	33	7-89	.	.		.	.		31	0	0-21	7	0	0-60	1	0	0-100	54	2	1-15	3	0	0-100
BALDWIN CO HOSP MILLEDGEVILLE GA 31061	14	7	6-54	10	40	13-68	21	5	2-30	2	0	0-100	79	3	1-12	54	6	2-18	6	0	0-97	71	3	1-12	38	0	0-26
BANKS-JACKSON-COMMERCE HOS COMMERCE GA 30529	8	25	3-61	2	0	2-90	4	0	0-78	.	.		52	4	1-16	12	0	0-43	3	0	0-100	25	4	1-24	25	4	0-47
BARROW MEDICAL CENTER WINDER GA 30680	10	30	5-59	6	67	6-70	10	0	0-48	2	0	0-100	54	2	1-15	9	0	0-52	.	.		33	0	1-20	24	0	0-40
BERRIEN CO HOSP NASHVILLE GA 31639	6	17	4-69	2	50	2-90	.	.		.	.		65	3	1-14	6	0	1-62	1	0	0-100	60	0	1-14	18	0	0-45
BLECKLEY CO HOSP COCHRAN GA 31014	1	0	0-100	2	50	1-89	.	.		.	.		42	0	1-17	5	20	0-86	.	.		40	3	1-18	6	0	0-86
BOWDON AREA HOSP BOWDON GA 30108	1	100	1-97	3	0	3-84	2	0	0-96	1	100	0-100	34	0	1-20	10	0	1-47	1	0	0-100	19	0	0-31	14	0	0-61
BROOKS CO HOSP QUITMAN GA 31643	3	33	1-82	5	40	10-80	.	.		.	.		19	5	1-30	3	33	0-82	.	.		22	0	0-26	2	0	0-100
BULLOCH CO HOSP STATESBORO GA 30458	7	43	5-68	9	44	13-71	31	6	2-24	6	0	0-100	134	4	2-10	73	4	2-15	10	0	0-94	119	9	2-10	67	0	0-11
BURKE CO HOSP WAYNESBORO GA 30830	4	25	3-77	4	0	6-80	2	0	0-96	.	.		36	0	1-19	15	13	1-37	5	0	0-100	29	3	1-21	8	0	0-90
CALHOUN MEMORIAL HOSP ARLINGTON GA 31713	15	20	6-52	.	.		.	.		.	.		28	4	1-23	6	0	0-64	.	.		25	0	1-24	4	0	0-99
CANDLER CO HOSP METTER GA 30439	2	0	1-90	8	25	11-71	3	0	0-92	.	.		48	4	1-15	16	19	1-35	5	0	0-100	27	7	1-22	5	0	0-87
CANDLER GENERAL HOSP SAVANNAH GA 31401	18	11	7-51	44	16	20-51	56	14	4-21	121	0	0-7	358	4	3-8	184	6	2-11	46	0	0-28	159	7	2-10	137	0	0-6
CHARLTON MEMORIAL HOSP FOLKSTON GA 31537	3	0	1-83	8	38	12-72	.	.		.	.		16	0	0-35	2	50	1-89	2	0	0-100	31	0	0-20	6	17	0-76
CHARTER NORTHSIDE HOSPITAL MACON GA 31210	11	18	2-53	8	38	10-70	25	20	2-28	3	0	0-100	56	7	1-15	31	6	1-23	4	0	0-100	51	12	1-15	88	3	0-9
CHATTOOGA CO HOSP SUMMERVILLE GA 30747	6	33	6-73	3	100	6-87	1	0	0-100	1	0	0-100	11	0	0-56	14	29	1-38	.	.		28	4	1-23	5	0	0-84
CLAY CO FT GAINES HOSP FORT GAINES GA 31751	9	0	4-60	.	.		.	.		.	.		12	0	0-47	.	.		.	.		25	12	1-25	2	0	0-100
CLAYTON GENERAL HOSP-RIVERDALE GA 30274	16	13	5-50	20	25	15-57	65	11	3-19	6	0	0-100	177	6	2-10	134	3	1-11	28	4	0-61	174	2	2-8	142	3	0-6
CLINCH MEM HOSP HOMERVILLE GA 31634	9	56	6-62	.	.		1	0	0-98	.	.		22	5	0-27	8	13	0-55	.	.		29	10	1-22	17	0	0-72
COBB HOSP AUSTELL GA 30001	21	14	6-47	21	48	24-66	44	14	3-22	6	0	0-100	175	2	2-9	67	10	2-16	13	0	0-100	253	4	2-8	63	3	0-12
COBB MEMORIAL HOSP ROYSTON GA 30662	14	29	6-53	12	25	16-68	9	11	0-51	.	.		75	5	1-13	31	16	2-24	6	0	0-100	57	0	1-14	34	0	0-20
COFFEE REGIONAL HOSPITAL DOUGLAS GA 31533	12	33	4-54	11	45	15-69	12	0	1-42	.	.		89	0	1-11	30	0	1-24	9	0	0-100	62	2	2-14	18	0	0-50

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
COLISEUM PARK HOSP MACON GA 31213	GA-41	1555	8	6-13	153	18	14-31	36	14	15-45	46	11	4-27	39	26	13-40	36	53	22-53	27	22	9-42	108	19	11-28
COLQUITT REGIONAL MEDICAL MOULTRIE GA 31768	GA-42 *	1078	13	8-15	47	26	12-38	41	29	15-42	25	28	5-36	58	19	13-35	48	46	24-51	33	15	8-38	97	15	10-27
CRAWFORD W LONG HOSP ATLANTA GA 30365	GA-43 *	3280	9	8-14	251	18	20-36	72	26	19-41	66	14	11-33	110	22	15-31	103	23	26-46	62	19	10-33	189	19	12-25
CRISP CO HOSP CORDELE GA 31015	GA-44	723	16	8-16	27	37	21-57	22	41	13-50	14	21	5-47	48	31	12-35	22	73	20-59	40	30	8-36	58	21	9-30
DECATUR HOSP DECATUR GA 30030	GA-45	216	4	2-11	18	6	4-41	3	0	3-82	6	0	1-63	2	50	2-90	.	.		2	0	0-91	11	0	2-46
DEKALB GENERAL HOSP DECATUR GA 30033	GA-46	3825	12	9-15	315	20	16-31	165	40	21-36	85	20	8-27	171	22	16-30	157	36	30-47	119	21	12-31	277	19	14-27
DOCTORS HOSP TUCKER GA 30084	GA-47 *	557	11	6-14	21	24	11-49	12	33	10-59	4	25	1-75	35	20	9-36	15	60	17-64	16	6	4-44	43	16	7-30
DOCTORS HOSP OF COLUMBUS COLUMBUS GA 31901	GA-48 *	1154	15	8-15	68	15	13-35	39	36	17-46	19	37	8-47	38	34	13-41	35	46	24-56	21	33	11-49	89	24	9-27
DOCTORS MEMORIAL HOSP ATLANTA GA 30365	GA-49 *	284	7	5-14	17	24	16-60	8	13	8-66	6	33	1-63	1	0	0-97	1	100	2-98	7	0	2-60	23	13	7-40
DODGE CO HOSP EASTMAN GA 31023	GA-50	532	14	10-18	25	52	19-56	20	20	15-55	7	57	7-67	29	31	11-42	14	57	19-67	16	6	6-47	81	27	11-30
DONALSONVILLE HOSP INC DONALSONVILLE GA 31745	GA-51	266	7	8-18	2	0	0-92	12	33	11-60	6	17	4-67	12	25	5-50	12	33	14-65	39	3	5-31	47	0	8-32
DOOLY MEDICAL CENTER VIENNA GA 31092	GA-52 *	260	15	9-19	5	40	4-72	8	38	7-65	12	8	4-49	15	33	9-52	8	88	13-72	13	23	7-54	27	15	8-38
DORMINY MEDICAL CENTER FITZGERALD GA 31750	GA-53	565	16	7-15	9	67	11-67	26	38	13-47	5	0	1-68	27	30	11-43	20	70	21-62	13	23	4-47	70	17	8-28
DOUGLAS GENERAL HOSP DOUGLASVILLE GA 30134	GA-54 *	725	13	9-17	34	32	14-46	25	20	16-52	19	32	11-50	37	30	13-41	14	36	19-67	10	30	7-59	75	20	10-29
EARLY MEMORIAL HOSP BLAKELY GA 31723	GA-55 *	384	12	11-20	14	79	22-71	40	28	20-50	4	0	1-74	18	17	12-52	6	50	13-80	12	17	4-50	50	14	11-35
EFFINGHAM CO HOSP SPRINGFIELD GA 31329	GA-56 *	185	6	7-18	.	.		9	33	9-64	1	0	0-97	7	14	4-61	5	60	9-79	9	11	5-58	40	8	8-33
ELBERT MEMORIAL HOSP ELBERTON GA 30635	GA-57 *	496	14	9-17	21	52	18-58	10	60	9-61	14	14	3-44	31	23	11-41	14	21	16-63	25	16	7-40	65	14	10-30
EMANUEL CO HOSP SWAINSBORO GA 30401	GA-58 *	642	12	9-17	16	50	12-56	17	29	12-53	7	0	2-59	45	27	13-39	19	68	20-62	28	0	4-34	90	16	9-27
EMORY UNIVERSITY HOSP ATLANTA GA 30322	GA-59 *	4574	7	7-13	443	18	22-36	48	23	17-43	51	18	15-41	83	22	15-34	79	16	24-46	39	26	10-39	128	24	15-31
EVANS MEMORIAL HOSP CLAXTON GA 30417	GA-60	235	17	11-22	6	50	7-72	12	25	9-57	5	20	4-71	20	25	9-45	18	39	20-64	11	0	3-50	41	22	10-36
FAIRVIEW PARK HOSP DUBLIN GA 31021	GA-61 *	1701	11	9-15	98	19	16-37	52	23	16-41	33	24	7-35	53	32	12-35	71	42	31-55	58	16	8-31	174	20	13-27
FANNIN REGIONAL HOSP BLUE RIDGE GA 30513	GA-62 *	412	17	9-18	21	62	12-50	22	41	16-54	16	19	8-50	15	20	8-50	15	47	17-63	11	45	3-50	52	15	11-37
FLOYD MEDICAL CENTER ROME GA 30161	GA-63	2306	13	8-15	179	27	18-35	84	29	17-37	49	14	7-31	109	25	14-30	104	33	27-47	34	9	5-32	202	23	12-26
GA BAPTIST HOSP ATLANTA GA 30312	GA-64 *	3224	11	7-13	194	20	15-31	79	19	18-38	73	22	9-30	129	29	15-30	78	31	27-50	90	32	12-33	221	22	12-25
GA REGIONAL HOSP AUGUSTA M AUGUSTA GA 30812	GA-65 *	21	5	1-29		.		.	.		.	.			.		.	.		.	.		1	0	0-98
GILMAN HOSP SAINT MARYS GA 31558	GA-66 *	157	8	6-18	2	100	5-93	6	0	7-72	2	0	0-92	15	7	9-52	3	33	5-86	6	17	3-66	14	29	4-45

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
COLISEUM PARK HOSP MACON GA 31213	16	13	3-47	9	22	11-68	30	0	1-24	7	0	0-100	185	2	2-8	78	3	0-14	35	3	0-74	84	4	1-11	161	1	0-6
COLQUITT REGIONAL MEDICAL MOULTRIE GA 31768	16	6	3-47	11	36	10-62	23	9	2-30	2	0	0-100	126	4	2-11	84	10	1-13	10	0	0-100	99	5	2-11	34	3	0-20
CRAWFORD W LONG HOSP ATLANTA GA 30365	24	21	7-46	21	38	22-64	62	8	4-20	34	0	0-43	264	6	4-10	219	4	1-10	21	0	0-85	481	4	3-8	140	4	1-7
CRISP CO HOSP CORDELE GA 31015	27	22	7-45	10	60	12-67	9	0	0-51	.	.		68	4	2-14	64	3	0-15	6	0	0-100	74	0	1-12	30	0	0-25
DECATUR HOSP DECATUR GA 30030	1	0	2-98	.	.		.	.		42	0	0-48	26	4	0-24	7	0	0-75	6	0	0-100	8	0	0-58	11	0	0-81
DEKALB GENERAL HOSP DECATUR GA 30033	31	29	11-48	52	44	20-49	145	8	3-14	6	0	0-100	425	5	2-7	209	3	1-10	56	0	0-51	279	1	2-8	232	1	0-5
DOCTORS HOSP TUCKER GA 30084	4	25	3-78	17	47	18-64	13	0	1-40	.	.		70	4	1-12	24	0	1-27	5	0	0-98	31	3	1-20	62	0	0-15
DOCTORS HOSP OF COLUMBUS COLUMBUS GA 31901	20	25	6-48	29	66	22-58	21	5	1-29	5	0	0-100	105	5	2-11	138	4	1-11	27	0	0-59	81	9	1-12	34	9	0-19
DOCTORS MEMORIAL HOSP ATLANTA GA 30365	.	.		1	0	1-97	2	0	0-98	28	0	0-71	32	3	0-20	26	4	1-25	6	0	0-97	23	0	1-26	14	0	0-58
DODGE CO HOSP EASTMAN GA 31023	8	13	4-62	18	22	15-59	3	0	0-94	.	.		51	2	1-15	12	8	1-42	2	0	0-100	41	0	1-17	21	0	0-43
DONALSONVILLE HOSP INC DONALSONVILLE GA 31745	2	50	3-91	2	50	2-90	1	0	0-99	.	.		19	5	0-30	21	5	1-30	3	0	0-100	23	0	1-26	13	0	0-94
DOOLY MEDICAL CENTER VIENNA GA 31092	8	25	2-60	11	64	18-72	.	.		.	.		23	0	0-26	13	0	2-41	1	0	0-100	31	0	1-21	3	0	0-100
DORMINY MEDICAL CENTER FITZGERALD GA 31750	7	43	5-66	15	47	14-60	7	43	1-57	1	0	0-100	68	4	1-13	17	18	1-34	4	0	0-100	85	5	1-11	22	5	0-39
DOUGLAS GENERAL HOSP DOUGLASVILLE GA 30134	5	20	4-73	17	53	19-64	23	4	2-30	4	0	0-100	75	5	3-15	40	10	3-24	5	0	0-99	92	2	2-12	32	0	0-25
EARLY MEMORIAL HOSP BLAKELY GA 31723	11	18	5-57	2	0	3-92	2	0	0-97	.	.		50	0	2-18	6	0	0-67	.	.		45	7	1-16	7	14	0-61
EFFINGHAM CO HOSP SPRINGFIELD GA 31329	.	.		2	0	2-90	1	0	0-100	.	.		23	0	0-26	7	0	0-59	1	0	0-100	30	0	1-22	1	0	0-100
ELBERT MEMORIAL HOSP ELBERTON GA 30635	11	45	7-60	8	38	12-73	3	0	1-81	1	0	0-100	41	5	2-19	29	0	1-24	1	0	0-100	47	9	1-17	13	0	0-86
EMANUEL CO HOSP SWAINSBORO GA 30401	10	40	5-59	21	52	19-61	3	33	1-81	.	.		66	6	1-14	39	3	3-24	7	0	0-99	55	0	1-14	20	0	0-41
EMORY UNIVERSITY HOSP ATLANTA GA 30322	74	11	3-32	11	45	16-69	18	0	2-34	185	1	0-4	260	6	5-12	119	2	1-12	39	3	0-29	1094	5	3-7	187	1	0-5
EVANS MEMORIAL HOSP CLAXTON GA 30417	3	67	4-86	4	0	7-83	5	0	0-72	.	.		18	11	1-31	8	13	0-55	1	0	0-100	19	5	1-30	4	0	0-100
FAIRVIEW PARK HOSP DUBLIN GA 31021	16	19	8-54	22	23	21-62	34	6	2-23	12	0	0-99	206	4	3-10	128	2	1-12	10	0	0-100	168	2	2-9	52	2	0-15
FANNIN REGIONAL HOSP BLUE RIDGE GA 30513	5	60	3-73	1	100	2-98	.	.		.	.		78	4	2-13	17	0	0-34	.	.		32	13	1-21	14	0	0-67
FLOYD MEDICAL CENTER ROME GA 30161	14	29	5-52	34	38	16-49	108	8	3-15	4	0	0-99	207	9	2-9	140	2	1-11	39	3	0-32	170	1	2-9	112	5	0-7
GA BAPTIST HOSP ATLANTA GA 30312	31	45	11-49	20	35	16-58	92	11	4-17	23	0	0-85	288	5	2-8	155	9	3-13	26	4	0-81	349	7	2-7	208	2	0-5
GA REGIONAL HOSP AUGUSTA M AUGUSTA GA 30812	.	.		.	.		.	.		.	.		.	.		.	.		.	.		1	0	0-100	.	.	
GILMAN HOSP SAINT MARYS GA 31558	3	0	0-85	1	0	2-99	.	.		.	.		15	7	0-36	7	0	0-67	1	0	0-100	16	0	0-34	6	0	0-95

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
GLYNN BRUNSWICK MEMORIAL H BRUNSWICK GA 31520	GA-67	2481	10	9-15	186	20	18-35	81	22	18-38	62	13	7-29	159	21	15-30	65	49	29-53	65	18	11-35	208	12	12-25
GORDON HOSP CALHOUN GA 30701	GA-68 *	456	14	9-18	12	25	5-50	21	52	12-50	17	12	3-40	28	11	9-39	24	33	23-61	11	18	2-48	71	23	13-34
GRADY GENERAL HOSP CAIRO GA 31728	GA-69 *	376	13	9-18	13	31	6-51	17	35	13-55	10	30	3-51	31	23	11-40	12	17	13-63	18	28	7-47	38	21	9-36
GRADY MEMORIAL HOSP- ATLANTA GA 30303	GA-70	3859	17	8-15	290	28	16-31	204	31	18-31	108	17	7-24	209	17	14-26	112	42	26-45	140	20	8-26	394	27	12-23
GWINNETT HOSP SYSTEM LAWERENCEVILLE GA 30245	GA-71	1920	11	8-15	99	33	17-38	68	24	17-39	48	17	7-31	95	21	15-32	75	35	25-48	41	10	7-34	233	16	13-26
HABERSHAM CO MEDICAL CENTE DEMOREST GA 30535	GA-72 *	451	16	10-18	14	57	15-63	24	42	16-52	7	29	3-61	18	17	8-46	16	56	20-66	5	0	1-68	84	23	11-29
HAMILTON MEDICAL CENTER DALTON GA 30720	GA-73	2197	12	8-14	106	23	14-33	57	28	17-41	51	12	10-34	96	24	14-31	91	44	27-48	35	11	7-35	266	20	12-24
HANCOCK MEMORIAL HOSP SPARTA GA 31087	GA-74 *	174	14	11-23	1	100	1-98	9	33	8-62	7	14	2-59	15	27	8-50	4	75	11-86	14	21	7-51	42	17	13-40
HART CO HOSP HARTWELL GA 30643	GA-75	306	18	10-20	17	65	12-55	20	25	18-58	3	0	0-86	20	30	8-44	14	79	21-69	5	20	2-69	38	26	11-38
HCA PAYMYRA MEDICAL CENTER ALBANY GA 31703	GA-76	1317	10	7-14	108	20	15-35	59	32	18-41	45	18	7-31	39	23	12-39	29	41	20-55	13	15	4-47	88	25	11-29
HEARD CO MEMORIAL HOSP FRANKLIN GA 30217	GA-77 *	107	7	4-17	3	67	3-84	4	0	2-74	.	.		4	0	3-76	1	0	1-97	7	0	1-59	18	11	4-39
HENRIETTA EGLESTON HOSP FO ATLANTA GA 30322	GA-78 *	32	0	2-24	.	.		.	.		2	0	0-89	.	.		.	.		.	.		1	0	0-97
HENRY GENERAL HOSP STOCKBRIDGE GA 30281	GA-79	837	12	8-16	44	23	10-37	32	28	13-44	30	30	10-41	50	24	11-34	31	29	24-58	23	26	6-40	77	17	10-28
HIGGINS GENERAL HOSP BREMEN GA 30110	GA-80 *	507	16	9-17	11	0	3-50	22	41	15-52	13	38	4-47	26	27	9-40	13	69	17-66	27	15	5-37	84	24	13-32
HOUSTON MEDICAL CENTER WARNER ROBINS GA 31093	GA-81 *	1003	11	7-14	43	35	14-42	24	33	13-48	12	17	3-47	39	28	11-37	22	64	22-61	28	14	7-39	92	26	11-29
HUGHES SPALDING MEDICAL CE ATLANTA GA 30303	GA-82 *	283	10	5-14	12	50	10-59	4	25	7-81	7	14	1-59	20	20	7-43	2	50	8-96	10	10	6-57	15	33	6-48
HUGHSTON SPORTS MEDICINE H COLUMBUS GA 31909	GA-83 *	529	0	0-11	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
HUMANA HOSP OF AUGUSTA AUGUSTA GA 30910	GA-84 *	1546	11	8-15	55	33	16-41	53	25	16-41	32	19	7-35	61	20	13-35	29	41	22-57	68	24	12-35	146	22	12-27
HUMANA HOSPITAL GWINNETT SNELLVILLE GA 30278	GA-85	732	11	8-15	44	36	13-41	19	26	11-50	19	11	3-38	28	11	9-39	31	39	22-55	22	9	7-42	65	20	12-33
HUMANA HOSPITAL NEWNAN NEWNAN GA 30263	GA-86 *	593	10	7-14	17	29	11-53	20	30	10-48	9	0	1-51	27	15	10-42	18	33	19-62	19	32	7-46	54	20	8-30
HUMANA HOSPITAL-CARTERSVIL CARTERSVILLE GA 30120	GA-87	641	15	7-15	26	50	10-44	26	27	13-47	15	33	5-45	38	34	10-37	19	47	17-58	18	0	4-42	63	21	8-28
HUTCHESON MEDICAL CENTER FORT OGLETHORPE GA 30742	GA-88	1960	15	10-17	145	32	20-38	82	30	19-40	40	25	8-34	98	19	14-31	95	65	29-50	52	21	6-30	204	16	12-25
IRWIN CO HOSP OCILLA GA 31774	GA-89 *	211	13	9-20	3	33	4-84	15	47	10-53	3	33	6-87	8	38	4-58	7	29	14-76	14	7	6-50	30	17	11-41
JASPER MEMORIAL HOSP- MONTICELLO GA 31064	GA-90 *	99	19	9-24	1	100	0-99	9	67	10-66	3	33	1-81	3	0	1-81	5	60	13-84	4	0	1-75	13	8	4-46
JEFF DAVIS HOSP HAZLEHURST GA 31539	GA-91	338	13	8-18	11	64	18-71	11	27	10-61	13	8	4-46	21	33	9-44	9	67	13-69	16	6	4-43	68	19	11-31
JEFFERSON HOSP LOUISVILLE GA 30434	GA-92 *	269	14	10-21	1	0	0-99	13	15	13-60	9	0	4-56	16	19	8-48	7	43	11-73	18	22	5-43	58	31	11-34

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
GLYNN BRUNSWICK MEMORIAL H BRUNSWICK GA 31520	19	16	7-50	18	33	16-60	53	2	4-23	22	0	0-64	270	3	2-8	104	4	1-13	17	0	0-90	225	4	2-8	101	0	0-8
GORDON HOSP CALHOUN GA 30701	6	17	2-67	9	33	11-68	18	6	1-32	.	.		42	2	0-17	14	21	2-41	1	0	0-100	39	3	1-17	17	0	0-64
GRADY GENERAL HOSP CAIRO GA 31728	11	27	8-62	6	33	7-72	.	.		.	.		53	2	1-15	19	16	2-32	.	.		29	3	1-22	3	0	0-100
GRADY MEMORIAL HOSP- ATLANTA GA 30303	38	16	6-40	103	63	23-46	46	9	2-20	29	0	0-70	203	11	2-9	185	17	3-12	48	0	0-33	349	5	2-6	110	5	0-7
GWINNETT HOSP SYSTEM LAWERENCEVILLE GA 30245	19	16	4-46	23	30	18-58	54	6	2-18	2	0	0-100	239	4	2-8	89	9	2-15	13	0	0-99	159	3	1-8	86	1	0-10
HABERSHAM CO MEDICAL CENTE DEMOREST GA 30535	9	44	11-70	2	0	2-90	10	10	1-47	.	.		75	5	2-13	37	11	3-25	3	0	0-100	33	6	1-21	24	0	0-37
HAMILTON MEDICAL CENTER DALTON GA 30720	31	26	8-44	22	36	17-57	41	5	2-22	13	0	0-98	275	4	2-8	98	7	2-13	27	0	0-51	115	2	2-10	104	0	0-8
HANCOCK MEMORIAL HOSP SPARTA GA 31087	2	0	1-90	3	0	10-92	1	0	0-99	.			7	0	0-77	10	0	1-47	1	0	0-100	9	0	0-58	6	17	0-63
HART CO HOSP HARTWELL GA 30643	6	50	2-67	6	33	9-75	2	0	0-90	.	.		47	4	1-16	21	5	0-30		.		27	0	1-23	7	0	0-91
HCA PAYMYRA MEDICAL CENTER ALBANY GA 31703	12	17	6-57	3	67	6-87	54	9	3-21	11	0	0-94	168	3	2-9	102	1	1-12	10	0	0-100	50	12	2-16	151	0	0-6
HEARD CO MEMORIAL HOSP FRANKLIN GA 30217		.		.	.		.	.		.	.		11	0	0-50	1	0	0-99		.		13	8	0-40	3	0	0-100
HENRIETTA EGLESTON HOSP FO ATLANTA GA 30322	5	0	0-80	.	.		.	.		.	.		2	0	0-99	1	0	0-100	.	.		.	.		.	.	
HENRY GENERAL HOSP STOCKBRIDGE GA 30281	7	0	5-67	7	43	9-71	22	5	2-31	7	14	0-100	62	13	2-17	60	5	1-16	6	0	0-99	107	4	2-10	34	3	0-21
HIGGINS GENERAL HOSP BREMEN GA 30110	32	6	10-47	.	.		1	0	0-99	.	.		48	4	1-16	24	8	1-28	3	0	0-100	28	0	1-22	7	0	0-96
HOUSTON MEDICAL CENTER WARNER ROBINS GA 31093	42	21	13-47	12	25	12-63	46	9	3-21	8	0	0-100	102	5	1-10	46	2	0-19	9	0	0-100	84	0	1-12	87	0	0-9
HUGHES SPALDING MEDICAL CE ATLANTA GA 30303	3	0	1-83	.	.		1	0	0-100	.	.		16	0	1-34	17	12	1-33	2	0	0-100	20	0	1-28	16	0	0-85
HUGHSTON SPORTS MEDICINE H COLUMBUS GA 31909	.	.		.	.		23	0	1-28	.	.		.	.		.	.		.	.		.	.		429	0	0-4
HUMANA HOSP OF AUGUSTA AUGUSTA GA 30910	27	7	10-48	21	33	21-63	47	13	2-20	30	0	0-52	145	8	2-10	53	6	3-20	8	0	0-100	120	5	2-10	120	0	0-7
HUMANA HOSPITAL GWINNETT SNELLVILLE GA 30278	3	33	2-83	6	33	7-72	28	4	2-26	3	0	0-100	64	9	1-14	44	5	1-18	8	0	0-100	73	0	1-13	59	0	0-13
HUMANA HOSPITAL NEWNAN NEWNAN GA 30263	6	17	3-67	3	33	4-85	22	5	2-30	1	0	0-100	42	12	1-18	35	0	0-22	2	0	0-100	56	9	1-14	42	0	0-17
HUMANA HOSPITAL-CARTERSVIL CARTERSVILLE GA 30120	5	80	5-75	7	71	9-71	29	3	2-25	3	0	0-100	66	5	1-13	30	10	2-25	7	0	0-100	59	0	1-14	23	0	0-50
HUTCHESON MEDICAL CENTER FORT OGLETHORPE GA 30742	24	42	12-52	41	41	23-55	67	9	4-20	.	.		206	5	2-9	108	6	2-14	20	5	0-97	166	7	2-9	72	4	0-10
IRWIN CO HOSP OCILLA GA 31774	4	50	2-77	1	0	0-97	.	.		.	.		22	0	0-27	5	0	0-71	.	.		36	3	1-19	2	0	0-100
JASPER MEMORIAL HOSP- MONTICELLO GA 31064	5	40	7-78	.	.		.	.		.	.		6	0	0-80	6	0	1-62	.	.		4	0	0-85	2	0	0-98
JEFF DAVIS HOSP HAZLEHURST GA 31539	4	25	2-76	1	0	0-97	1	0	0-100	.	.		42	0	0-16	11	27	1-45	1	0	0-100	22	5	0-26	6	0	0-100
JEFFERSON HOSP LOUISVILLE GA 30434	2	0	1-90	13	15	13-63	.	.		.	.		21	14	1-28	15	0	1-37	.	.		14	0	0-38	6	0	0-94

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
JENKINS CO HOSP MILLEN GA 30442	GA-93 *	220	10	7-17	2	100	6-94	2	0	1-89	3	67	1-81	13	23	6-50	8	50	14-74	9	0	6-60	57	12	8-29
JESSE PARKER WILLIAMS HOSP ATLANTA GA 30308	GA-94 *	597	8	8-15	51	20	13-38	15	7	13-57	16	13	7-48	17	24	10-50	6	33	8-73	27	4	5-36	66	8	8-28
JOHN D ARCHBOLD MEMORIAL H THOMASVILLE GA 31792	GA-95 *	2399	10	8-15	176	19	15-32	123	25	19-37	50	22	9-33	75	16	16-37	67	46	27-51	25	0	5-37	174	19	13-28
JOHN M MEADOWS MEMORIAL HO VIDALIA GA 30474	GA-96 *	593	16	10-18	37	43	14-44	25	36	14-48	9	0	3-55	37	27	11-38	30	40	23-58	14	7	4-45	108	23	13-30
KENNESTONE HOSP MARIETTA GA 30060	GA-97	3543	10	7-14	241	31	18-34	190	23	21-35	80	13	11-32	103	24	14-31	90	42	25-47	41	2	5-31	273	14	11-23
KENNESTONE HOSPITAL AT WIN MARIETTA GA 30067	GA-98	353	8	5-13	26	15	9-43	7	14	6-66	8	13	3-57	10	30	6-55	2	50	2-90	5	0	2-69	30	20	6-34
LAKESIDE COMMUNITY HOSP CUMMING GA 30130	GA-99 *	359	13	7-16	7	14	4-63	13	15	11-59	3	0	1-81	19	26	10-48	16	44	20-66	13	15	5-50	45	24	8-32
LANIER PARK HOSP GAINESVILLE GA 30505	GA-100	1230	9	8-15	89	24	20-42	44	18	16-43	22	14	5-38	34	24	10-39	35	40	25-58	15	13	4-44	120	21	13-30
LIBERTY MEMORIAL HOSP HINESVILLE GA 31313	GA-101*	272	15	9-20	6	50	6-70	11	9	8-57	9	22	4-55	19	26	11-49	7	14	14-77	10	10	4-54	43	16	12-38
LOUIS SMITH MEMORIAL HOSP LAKELAND GA 31635	GA-102	243	13	8-19	2	50	1-89	1	0	0-97	4	25	2-75	25	32	10-42	7	57	12-74	16	13	6-47	46	15	11-36
MACON CO MEDICAL CENTER MONTEZUMA GA 31063	GA-103*	337	13	9-19	14	21	7-52	14	36	10-55	11	0	2-47	23	9	9-43	7	71	17-80	13	8	4-47	56	14	11-34
MARION MEMORIAL HOSPITAL BUENA VISTA GA 31803	GA-104	159	11	9-22	2	100	3-91	10	20	12-66	1	0	1-97	6	17	3-64	2	100	5-94	27	11	8-41	18	0	4-39
MCDUFFIE CO HOSP THOMSON GA 30824	GA-105*	373	14	10-19	6	83	9-75	15	27	12-57	9	22	4-56	17	29	11-53	12	42	14-65	22	18	6-41	84	15	11-30
MEDICAL SURG CTR OF CENTR MILLEDGEVILLE GA 31062	GA-106*	410	11	9-18	10	40	16-71	7	0	4-63	15	13	7-49	6	17	4-66	15	33	17-63	15	7	4-45	87	20	13-32
MEDICAL CENTER OF CENTRAL MACON GA 31208	GA-107	3277	15	9-15	176	24	19-36	136	37	20-36	69	23	9-31	140	26	14-29	145	41	29-47	104	21	9-28	227	22	13-27
MEDICAL COLLEGE OF GEORGIA AUGUSTA GA 30902	GA-108	1495	9	7-14	139	21	23-42	38	21	14-42	19	21	8-47	35	17	11-39	15	40	17-64	45	16	7-33	70	14	10-30
MEMORIAL HOSP BAINBRIDGE GA 31717	GA-109	755	13	8-16	29	45	16-51	49	35	18-44	21	14	5-39	44	34	13-38	15	67	20-67	34	12	8-38	92	14	9-26
MEMORIAL HOSP WAYCROSS GA 31501	GA-110	1418	13	8-15	96	23	13-33	55	36	17-41	32	22	8-38	59	31	14-36	72	56	26-50	33	15	6-35	101	26	12-30
MEMORIAL HOSP OF ADEL INC ADEL GA 31620	GA-111*	641	13	9-17	18	61	15-58	27	30	16-50	21	29	5-40	33	39	13-43	23	26	22-60	38	8	4-30	104	12	9-25
MEMORIAL HOSP OF WASHINGTO SANDERSVILLE GA 31082	GA-112*	519	17	11-20	20	30	8-46	43	35	17-45	19	21	4-38	37	30	11-38	28	32	23-59	8	0	4-59	94	19	12-30
MEMORIAL MEDICAL CENTER SAVANNAH GA 31403	GA-113	2981	11	9-15	184	23	20-37	96	30	18-37	49	18	9-34	131	21	16-31	112	32	26-45	55	25	10-35	212	17	14-27
MERIWETHER MEMORIAL HOSP WARM SPRINGS GA 31830	GA-114*	159	18	8-20	2	50	0-90	9	33	7-61	6	17	3-65	9	56	6-59	3	33	5-86	15	27	5-47	16	25	8-49
METROPOLITAN HOSP ATLANTA GA 30327	GA-115*	336	0	0-15	4	0	3-76	.	.		.	.		.	.		.	.		.	.		.	.	
MIDDLE GEORGIA HOSP- MACON GA 31297	GA-116*	1275	9	8-15	125	22	17-36	35	20	15-45	25	20	5-37	56	25	14-37	38	26	22-53	18	22	8-47	110	13	11-27
MILLER CO HOSP COLQUITT GA 31737	GA-117*	223	17	9-19	11	73	15-67	15	40	12-56	4	25	1-74	9	22	4-56	13	46	19-69	9	11	1-53	29	21	6-34
MINNIE G BOSWELL MEMORIAL GREENSBORO GA 30642	GA-118*	291	19	9-19	9	44	11-68	24	38	15-51	5	60	1-68	14	21	6-48	9	33	7-62	20	35	10-49	39	33	9-35

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
JENKINS CO HOSP MILLEN GA 30442	4	0	1-77				3	0	0-92	.	.		34	0	1-19	7	0	0-72	4	0	0-96	10	0	0-47	9	0	0-88
JESSE PARKER WILLIAMS HOSP ATLANTA GA 30308	5	40	6-76	4	75	5-80	14	21	1-38	.	.		84	1	2-13	29	14	2-26	2	0	0-100	13	0	0-39	24	0	0-35
JOHN D ARCHBOLD MEMORIAL H THOMASVILLE GA 31792	56	18	13-44	21	57	19-61	76	11	3-18	14	0	0-77	217	3	2-9	125	3	1-12	19	0	0-33	164	3	3-11	184	2	0-5
JOHN M MEADOWS MEMORIAL HO VIDALIA GA 30474	7	14	4-66	3	33	6-87	3	0	1-81	.	.		54	6	1-14	37	11	2-21	8	0	0-100	49	0	1-16	7	0	0-99
KENNESTONE HOSP MARIETTA GA 30060	35	17	11-47	23	48	21-61	114	9	4-15	12	0	0-81	329	4	2-8	176	4	1-10	49	2	0-30	269	3	2-7	356	2	0-4
KENNESTONE HOSPITAL AT WIN MARIETTA GA 30067	8	0	2-60	1	100	1-97	12	0	1-42	1	0	0-100	20	5	0-29	57	0	0-17	5	0	0-100	13	8	1-39	47	4	0-21
LAKESIDE COMMUNITY HOSP CUMMING GA 30130	4	0	3-78	5	80	8-78	13	0	1-40	1	0	0-100	48	4	1-15	22	18	1-28	2	0	0-100	32	6	1-21	20	0	0-42
LANIER PARK HOSP GAINESVILLE GA 30505	9	44	3-58	3	0	4-84	19	0	2-34	8	0	0-100	147	1	2-10	112	8	2-13	12	0	0-99	120	0	2-10	69	0	0-11
LIBERTY MEMORIAL HOSP HINESVILLE GA 31313	11	36	4-55	3	33	8-89	.	.		.	.		23	26	2-28	16	31	2-38	3	0	0-100	19	0	0-29	5	0	0-100
LOUIS SMITH MEMORIAL HOSP LAKELAND GA 31635	.	.		4	75	12-88	.	.		.	.		34	3	1-19	3	33	0-83	.	.		23	4	1-26	4	0	0-100
MACON CO MEDICAL CENTER MONTEZUMA GA 31063	9	44	9-68	7	29	13-76	.	.		.	.		43	2	1-17	17	6	1-34	5	20	0-99	22	0	1-26	7	0	0-89
MARION MEMORIAL HOSPITAL BUENA VISTA GA 31803	2	0	1-90	9	22	15-74	1	0	0-99	.			17	0	0-34	9	0	0-51	.	.		10	10	0-53	5	0	1-67
MCDUFFIE CO HOSP THOMSON GA 30824	6	17	4-70	9	67	10-67	1	0	0-100	.	.		19	5	0-31	26	4	2-28	.	.		24	4	0-25	15	0	0-57
MEDICAL SURG CTR OF CENTR MILLEDGEVILLE GA 31062	2	0	0-93	9	44	11-68	9	0	1-50	8	0	0-96	32	3	1-21	21	0	1-29	1	0	0-100	28	0	1-23	5	0	0-97
MEDICAL CENTER OF CENTRAL MACON GA 31208	27	22	7-45	38	47	20-52	111	9	4-16	20	0	0-89	179	7	3-11	108	9	2-14	19	0	0-88	371	5	3-8	195	2	1-5
MEDICAL COLLEGE OF GEORGIA AUGUSTA GA 30902	55	9	5-36	6	33	10-77	26	12	2-27	53	0	0-24	108	7	3-14	35	6	2-22	20	0	0-86	117	2	2-10	76	3	1-10
MEMORIAL HOSP BAINBRIDGE GA 31717	7	29	3-63	10	50	14-69	1	0	0-100	.	.		126	1	2-10	25	4	1-27	11	0	0-97	66	2	1-13	25	0	0-27
MEMORIAL HOSP WAYCROSS GA 31501	9	11	6-62	22	41	18-59	62	3	2-17	20	0	0-94	170	2	2-10	117	2	1-12	18	0	0-99	142	3	2-10	63	2	0-13
MEMORIAL HOSP OF ADEL INC ADEL GA 31620	8	75	13-75	5	60	9-79	4	0	0-87	.	.		78	3	1-12	33	6	1-22	5	0	0-100	50	6	1-15	17	0	0-47
MEMORIAL HOSP OF WASHINGTO SANDERSVILLE GA 31082	9	22	8-66	11	55	12-65	2	50	0-96	.	.		40	5	1-18	7	14	1-58	1	0	0-100	44	0	1-16	18	0	0-59
MEMORIAL MEDICAL CENTER SAVANNAH GA 31403	38	5	8-42	19	32	20-63	62	16	4-21	5	0	0-100	198	6	3-10	170	6	2-12	25	0	0-59	243	5	3-10	219	2	0-5
MERIWETHER MEMORIAL HOSP WARM SPRINGS GA 31830	1	100	1-97	3	67	5-86	2	0	0-97	.	.		19	5	0-30	18	6	2-34	2	0	0-100	6	17	0-79	2	0	0-100
METROPOLITAN HOSP ATLANTA GA 30327	.	.		.	.		.	.		246	0	0-4	.	.		5	0	0-96	.	.		.	.		3	0	0-100
MIDDLE GEORGIA HOSP- MACON GA 31297	14	21	6-53	8	38	17-78	11	0	2-45	1	0	0-100	169	5	2-10	47	4	1-18	10	0	0-100	162	4	2-9	74	0	0-10
MILLER CO HOSP COLQUITT GA 31737	5	20	2-71	2	0	1-89	3	33	0-89	.	.		32	0	1-20	3	0	0-98	.	.		18	0	0-31	3	0	0-100
MINNIE G BOSWELL MEMORIAL GREENSBORO GA 30642	5	40	2-71	1	0	1-97	.	.		1	0	0-100	35	0	2-21	1	0	0-100	1	0	0-100	21	5	0-27	6	0	0-94

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MITCHELL CO HOSP CAMILLA GA 31730	GA-119*	150	16	10-24	4	75	5-79	19	26	15-55	.			11	27	6-54	11	45	17-70	15	20	7-49	15	7	5-46
MONROE CO HOSP FORSYTH GA 31029	GA-120*	438	18	8-17	16	50	7-47	11	64	11-61	11	45	5-52	25	24	9-41	17	35	16-59	13	23	4-48	85	18	11-29
MORGAN MEMORIAL HOSP MADISON GA 30650	GA-121*	183	14	9-20	4	50	3-76	8	63	13-72	8	0	3-57	10	10	8-60	6	50	14-81	18	17	4-41	18	22	7-45
MURRAY CO MEMORIAL HOSP CHATSWORTH GA 30705	GA-122*	249	14	7-16	7	43	6-67	4	25	3-76	4	50	1-75	14	0	6-48	5	33	12-78	15	13	3-42	46	33	9-33
NEWNAN HOSP NEWNAN GA 30264	GA-123*	1054	11	8-15	57	23	15-40	24	25	13-48	25	16	9-42	50	24	11-34	36	33	22-53	47	15	7-33	105	19	10-27
NEWTON GENERAL HOSPITAL COVINGTON GA 30209	GA-124*	755	13	9-17	31	26	12-44	38	29	14-43	20	25	6-41	46	11	12-36	46	37	24-53	20	30	11-51	122	22	11-27
NORTH FULTON MEDICAL CENTE ROSWELL GA 30076	GA-125	711	11	9-16	35	9	10-40	30	30	16-49	23	9	5-37	27	22	12-44	22	27	22-62	13	8	2-44	76	24	14-34
NORTH GEORGIA MEDICAL CENT ELLIJAY GA 30540	GA-126*	330	12	7-16	6	67	7-71	9	22	7-61	4	75	1-74	9	11	6-59	7	14	12-75	6	17	3-66	62	24	12-33
NORTHEAST GEORGIA MEDICAL GAINESVILLE GA 30505	GA-127	2542	11	8-15	160	31	17-35	88	32	18-38	60	13	9-31	103	22	14-31	101	38	29-49	45	18	8-34	194	17	14-27
NORTHSIDE HOSP ATLANTA GA 30342	GA-128*	1889	9	8-14	183	13	16-33	65	26	16-38	48	10	8-32	68	22	14-34	61	31	27-53	25	16	6-39	98	22	13-30
PARKWAY REGIONAL HOSP LITHIA SPRINGS GA 30057	GA-129*	675	9	7-15	35	20	15-47	19	26	11-49	14	50	5-47	30	20	9-38	13	46	15-63	18	17	9-49	63	5	10-30
PATTERSON HOSP CUTHBERT GA 31740	GA-130*	224	16	13-24	7	71	13-76	18	28	13-54	14	7	3-43	19	37	8-44	30	20	25-60	11	0	2-48	23	17	7-41
PAULDING MEMORIAL HOSP DALLAS GA 30132	GA-131	512	10	8-16	14	43	9-54	19	32	16-57	7	14	1-58	12	33	8-56	17	53	24-69	11	9	2-49	87	10	10-28
PEACH CO HOSP FORT VALLEY GA 31030	GA-132*	337	17	7-16	15	33	7-50	13	8	10-56	17	6	3-39	28	21	8-38	6	17	8-73	22	36	6-40	33	33	8-36
PERRY-GENERAL HOSP PERRY GA 31069	GA-133*	343	11	8-17	11	27	5-53	9	44	7-61	10	10	4-53	23	13	9-43	11	45	16-69	14	36	6-49	40	13	9-35
PHOEBE PUTNEY MEMORIAL HOS ALBANY GA 31703	GA-134*	2632	12	10-16	206	30	22-39	98	38	20-39	40	10	12-40	107	21	14-31	80	35	28-50	76	22	11-33	195	25	15-29
PHYSICIANS & SURGEONS HOSP ATLANTA GA 30381	GA-135*	326	7	6-15	9	33	5-58	8	0	7-63	9	22	3-54	24	13	8-41	7	57	16-80	7	14	3-61	28	4	6-34
PICKENS GENERAL HOSP- JASPER GA 30143	GA-136*	234	18	8-18	9	67	4-57	13	38	13-60	5	20	0-69	17	24	9-48	7	57	11-73	5	20	1-68	44	16	8-32
PIEDMONT HOSP ATLANTA GA 30309	GA-137*	4148	8	7-13	345	21	18-33	147	21	20-36	108	15	11-30	112	18	16-32	82	39	29-51	52	13	7-31	289	16	13-25
PIERCE CO HOSP BLACKSHEAR GA 31516	GA-138	184	11	7-18	6	83	7-72	7	14	6-66	2	0	0-93	17	35	9-49	4	50	9-84	10	0	2-51	27	15	6-35
POLK GENERAL HOSP CEDARTOWN GA 30125	GA-139*	352	8	7-16	7	71	12-75	5	20	5-73	5	0	0-69	11	9	6-53	7	29	10-72	19	16	3-39	65	12	9-30
PUTNAM GEN HOSP EATONTON GA 31024	GA-140	281	14	9-19	10	40	9-63	8	38	9-66	7	14	3-61	10	20	6-56	14	50	19-68	11	18	3-49	46	17	11-35
R J TAYLOR MEMORIAL HOSP- HAWKINSVILLE GA 31036	GA-141*	468	11	7-16	12	42	10-59	24	17	12-47	6	17	3-65	18	39	9-48	12	42	17-68	5	17	4-67	68	7	9-29
R T JONES MEMORIAL HOSP CANTON GA 30114	GA-142	708	13	9-17	39	36	14-44	18	11	11-51	17	24	6-46	36	25	12-39	24	38	23-61	25	32	8-41	91	25	12-30
RABUN CO MEMORIAL HOSP CLAYTON GA 30525	GA-143*	161	13	8-20	2	0	2-90	5	60	6-75	4	0	1-74	11	27	5-52	8	25	12-71	15	13	4-44	20	15	9-46
REDMOND PARK HOSP ROME GA 30161	GA-144	2317	9	8-14	203	22	16-32	64	20	18-40	37	11	7-34	120	16	16-32	86	37	26-48	33	12	13-45	143	16	13-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MITCHELL CO HOSP CAMILLA GA 31730	2	50	3-92	.	.		.	.		.	.		8	13	0-64	3	0	0-95	.	.		17	0	0-32	2	0	0-99
MONROE CO HOSP FORSYTH GA 31029	6	33	3-68	9	44	9-66	1	0	0-100	.	.		60	10	1-13	14	7	0-40	1	0	0-100	31	3	1-20	4	25	0-99
MORGAN MEMORIAL HOSP MADISON GA 30650	6	17	3-68	2	50	1-89	.	.		.	.		16	0	0-34	4	0	0-91	1	0	0-100	21	5	1-27	3	0	0-99
MURRAY CO MEMORIAL HOSP CHATSWORTH GA 30705	2	0	2-90	.	.		2	0	0-97	.			23	4	0-26	5	0	0-82	2	0	0-100	22	5	1-26	8	0	0-88
NEWNAN HOSP NEWNAN GA 30264	5	0	3-72	13	38	14-63	15	0	2-38	3	0	0-100	141	5	2-10	56	13	2-17	8	0	0-100	96	2	2-11	77	1	0-11
NEWTON GENERAL HOSPITAL COVINGTON GA 30209	7	0	2-63	3	33	4-85	30	0	2-25	13	0	0-98	74	5	1-13	34	12	1-22	7	0	0-100	53	4	1-15	41	0	0-22
NORTH FULTON MEDICAL CENTE ROSWELL GA 30076	3	67	3-83	7	57	10-72	36	6	3-24	7	0	0-98	76	5	2-13	44	9	3-21	5	0	0-100	43	5	1-17	22	5	0-47
NORTH GEORGIA MEDICAL CENT ELLIJAY GA 30540	1	0	1-97	.	.		4	25	1-74	1	0	0-100	45	4	1-16	13	0	1-40	1	0	0-100	35	6	1-20	11	0	0-73
NORTHEAST GEORGIA MEDICAL GAINESVILLE GA 30505	19	21	5-46	31	32	23-59	69	7	4-19	18	0	0-91	242	5	2-9	153	5	3-13	40	0	0-66	182	10	2-9	167	0	0-6
NORTHSIDE HOSP ATLANTA GA 30342	13	0	3-51	22	36	17-58	69	12	3-18	2	0	0-100	174	5	2-9	95	2	1-13	32	0	0-69	90	7	2-12	167	1	0-6
PARKWAY REGIONAL HOSP LITHIA SPRINGS GA 30057	7	29	5-67	4	25	6-81	18	6	1-33	3	0	0-100	58	3	1-14	22	9	1-29	3	0	0-100	73	3	1-12	24	0	0-45
PATTERSON HOSP CUTHBERT GA 31740	1	0	1-97	5	40	8-78	.	.		.	.		19	0	1-30	6	0	1-62	.	.		12	17	1-41	4	0	0-99
PAULDING MEMORIAL HOSP DALLAS GA 30132	8	13	4-62	8	13	8-66	5	0	0-73	.	.		50	4	1-16	19	0	1-31	1	0	0-100	59	3	1-14	16	0	0-82
PEACH CO HOSP FORT VALLEY GA 31030	7	71	2-63	8	50	10-69	4	0	0-77	.	.		52	12	1-15	6	17	0-71	.	.		30	0	1-21	5	0	0-99
PERRY-GENERAL HOSP PERRY GA 31069	8	25	5-64	5	40	10-80	.	.		.	.		47	4	1-16	16	6	0-35	2	0	0-100	30	3	1-21	8	0	0-92
PHOEBE PUTNEY MEMORIAL HOS ALBANY GA 31703	25	16	5-43	39	46	23-55	60	3	4-20	6	0	0-100	246	8	3-10	133	2	1-11	26	0	0-79	227	1	3-10	101	3	0-8
PHYSICIANS & SURGEONS HOSP ATLANTA GA 30381	3	33	2-82	3	33	5-86	2	0	0-92	.	.		16	6	1-34	26	4	0-26	4	0	0-100	27	0	0-22	16	0	0-52
PICKENS GENERAL HOSP- JASPER GA 30143	.	.		1	100	2-98	.	.		.	.		28	4	0-23	12	8	1-43	.	.		17	12	1-32	3	0	0-100
PIEDMONT HOSP ATLANTA GA 30309	32	6	7-43	23	48	23-63	119	7	4-16	263	1	0-3	417	4	2-8	183	5	2-11	80	0	0-20	215	6	3-9	485	1	0-3
PIERCE CO HOSP BLACKSHEAR GA 31516	1	100	0-98	2	0	1-89	1	0	0-100	.	.		12	8	0-52	1	0	0-100	.	.		28	0	0-22	5	0	0-100
POLK GENERAL HOSP CEDARTOWN GA 30125	1	100	1-97	7	29	10-73	.	.		.	.		17	0	0-35	31	10	4-29	.	.		61	2	1-14	16	0	0-74
PUTNAM GEN HOSP EATONTON GA 31024	2	0	0-90	2	0	10-98	8	13	1-54	.	.		39	5	1-19	4	0	1-50	1	0	0-100	27	4	1-23	5	0	0-99
R J TAYLOR MEMORIAL HOSP- HAWKINSVILLE GA 31036	19	26	6-48	2	50	5-93	7	29	1-57	.	.		54	7	1-15	16	0	0-49	2	0	0-96	52	2	1-15	27	0	0-28
R T JONES MEMORIAL HOSP CANTON GA 30114	6	17	4-69	9	56	17-75	8	13	0-54	.	.		119	4	2-12	29	3	1-24	5	0	0-100	38	3	1-19	25	0	0-33
RABUN CO MEMORIAL HOSP CLAYTON GA 30525	.	.		.	.		1	0	0-99	.	.		14	0	0-38	8	13	1-54	.	.		13	8	0-40	3	0	0-100
REDMOND PARK HOSP ROME GA 30161	20	15	7-48	24	42	22-62	31	6	2-24	10	0	0-100	227	6	2-8	156	2	1-11	14	0	0-42	315	3	2-7	137	0	0-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RIDGECREST HOSP CLAYTON GA 30525	GA-145	258	11	7-17	7	71	5-65	6	33	7-71	2	0	0-94	15	40	9-52	8	63	15-75	9	0	2-53	38	11	10-36
ROCKDALE HOSPITAL CONYERS GA 30207	GA-146	817	14	9-17	38	29	12-41	39	15	13-41	25	12	4-35	47	21	11-35	40	43	22-52	16	19	4-44	110	21	12-28
ROCKMART ARAGON HOSP ROCKMART GA 30153	GA-147*	221	14	8-18	8	75	8-66	10	30	9-61	5	20	1-69	11	27	5-52	9	44	17-74	7	14	3-62	34	9	9-36
SAINT JOSEPH'S HOSP OF DAH DAHLONEGA GA 30533	GA-148	262	20	10-20	9	67	13-70	16	31	13-56	8	63	3-57	9	56	6-60	11	73	16-69	8	25	4-60	49	24	11-35
SCREVEN CO HOSP SYLVANIA GA 30467	GA-149*	286	13	11-21	2	100	8-96	18	28	11-51	5	20	6-74	19	11	7-43	14	29	18-66	20	5	6-43	45	13	8-32
SHALLOWFORD CUMMUNITY HOSP CHAMBLEE GA 30341	GA-150*	700	8	6-13	34	12	10-39	20	30	11-48	18	0	4-40	33	18	10-39	21	43	17-57	20	5	4-39	41	10	7-30
SMITH HOSP HAHIRA GA 31632	GA-151*	285	6	7-16	6	17	4-67	3	0	2-81	14	7	2-42	16	25	8-48	6	33	11-77	22	5	4-37	40	5	8-33
SMYRNA HOSP SMYRNA GA 30080	GA-152*	689	18	9-17	25	20	12-47	24	46	13-48	16	44	5-45	26	31	9-41	26	58	23-60	26	23	9-43	77	26	11-30
SOUTH FULTON HOSP EAST POINT GA 30344	GA-153	2280	13	8-15	165	27	17-35	115	27	19-36	57	18	9-32	91	24	13-30	93	43	27-48	77	19	9-31	186	23	12-26
SOUTH GEORGIA MEDICAL CTR VALDOSTA GA 31603	GA-154*	2049	11	7-14	149	21	16-34	77	23	18-39	48	21	9-33	61	26	12-33	68	57	28-52	30	27	8-39	125	14	12-28
SOUTHWEST COMMUNITY HOSP ATLANTA GA 30331	GA-155*	462	13	8-17	25	16	8-41	11	27	8-58	24	21	7-40	33	24	11-40	13	15	15-64	14	14	9-55	54	30	9-31
ST FRANCIS HOSP COLUMBUS GA 31995	GA-156	2298	12	7-14	182	22	14-30	91	26	17-36	36	6	5-31	110	28	16-32	102	30	25-45	31	23	7-37	147	22	12-26
ST JOSEPH HOSP AUGUSTA GA 30910	GA-157	1804	10	8-15	126	19	15-34	62	26	19-43	35	23	6-33	81	27	16-35	37	49	27-59	52	27	11-36	164	22	12-26
ST JOSEPHS HOSP SAVANNAH GA 31419	GA-158	2545	8	8-14	153	22	18-35	87	25	21-41	43	14	9-35	135	16	16-31	56	32	26-52	56	16	10-35	199	16	11-24
ST JOSEPHS HOSP OF ATLANTA ATLANTA GA 30342	GA-159*	2598	10	7-14	263	28	18-34	42	38	16-43	52	17	9-32	84	19	15-33	84	46	28-50	32	13	7-36	121	18	11-27
ST MARYS HOSP OF ATHENS ATHENS GA 30601	GA-160	1948	10	7-14	123	12	14-33	63	27	18-41	29	31	7-37	77	18	14-33	47	36	23-51	31	23	5-35	136	19	12-27
STEPHENS CO HOSP TOCCOA GA 30577	GA-161*	819	14	10-17	51	29	16-42	29	34	14-47	17	18	5-44	67	31	14-34	30	30	20-54	27	15	8-41	101	16	13-30
STEWART WEBSTER HOSP RICHLAND GA 31825	GA-162*	162	7	7-19	6	67	20-87	7	0	8-68	3	0	1-82	12	0	4-48	3	67	7-88	8	0	3-59	19	5	4-38
SUMTER REGIONAL HOSP AMERICUS GA 31709	GA-163	1094	13	7-14	62	29	19-44	41	39	18-46	24	21	6-38	37	16	10-37	23	30	21-60	23	26	6-40	76	24	11-30
SYLVAN GROVE HOSP JACKSON GA 30233	GA-164*	208	15	7-18	4	25	11-86	11	36	9-60	6	0	2-63	6	17	4-67	2	50	6-94	12	17	3-48	41	15	7-31
TANNER MEDICAL CENTER VILL VILLA RICA GA 30180	GA-165	278	10	8-17	12	58	9-57	13	8	10-56	2	50	0-94	14	14	8-51	2	0	3-91	8	25	3-58	41	15	10-36
TANNER MEMORIAL CENTER CARROLLTON GA 30117	GA-166*	1553	12	8-15	75	36	17-40	61	33	19-42	31	26	7-36	77	31	16-36	44	36	24-53	50	12	7-32	180	23	13-28
TATTNALL MEM HOSP REIDSVILLE GA 30453	GA-167*	210	17	9-20	8	50	6-62	6	67	6-71	3	0	0-82	14	21	7-50	8	50	15-75	18	11	3-40	48	21	11-35
TERRELL COMMUNITY MEDICAL DAWSON GA 31742	GA-168*	138	15	9-23	2	100	5-93	9	33	8-63	4	0	1-74	13	38	6-50	7	29	12-74	9	11	3-55	17	24	8-48
THE MEDICAL CTR COLUMBUS GA 31901	GA-169	1762	14	8-15	108	29	14-34	76	37	18-39	33	21	7-35	88	20	12-30	54	39	26-53	45	20	7-33	130	30	12-27
THREE RIVERS HOSP & MEDICA MCRAE GA 31055	GA-170*	348	11	9-19	7	43	10-72	17	24	13-55	2	100	1-89	18	22	9-48	16	44	20-66	11	18	7-57	49	8	10-34

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RIDGECREST HOSP CLAYTON GA 30525	8	0	4-62	.	.		.	.		.	.		23	0	1-27	10	11	0-50	.	.		27	0	1-23	14	0	0-72
ROCKDALE HOSPITAL CONYERS GA 30207	21	33	6-47	12	58	16-68	26	0	2-27	5	0	0-100	86	2	2-12	36	11	1-21	15	0	0-99	61	7	1-14	21	5	0-43
ROCKMART ARAGON HOSP ROCKMART GA 30153	4	50	2-76	.	.		.	.		.	.		34	6	1-20	3	33	0-83	3	0	0-100	23	0	0-26	11	0	0-100
SAINT JOSEPH'S HOSP OF DAH DAHLONEGA GA 30533	.	.		3	33	5-86	7	0	0-58	.	.		29	7	1-23	14	14	1-38	3	0	0-100	26	4	1-23	7	0	0-95
SCREVEN CO HOSP SYLVANIA GA 30467	16	25	9-55	8	13	8-67	1	0	0-100	.	.		20	5	1-29	9	11	0-51	.	.		33	9	1-21	6	0	0-87
SHALLOWFORD CUMMUNITY HOSP CHAMBLEE GA 30341	7	14	2-63	6	33	10-76	17	6	0-34	2	0	0-100	52	4	1-15	29	3	0-24	6	0	0-99	101	6	1-11	53	0	0-14
SMITH HOSP HAHIRA GA 31632	6	33	6-71	5	20	7-77	5	0	0-79	1	0	0-100	39	3	1-17	10	0	1-47	.	.		15	0	0-39	8	0	0-94
SMYRNA HOSP SMYRNA GA 30080	8	38	4-63	20	40	20-63	10	20	1-47	.	.		65	9	2-15	55	7	2-18	10	0	0-91	54	9	1-15	38	3	0-26
SOUTH FULTON HOSP EAST POINT GA 30344	12	25	5-55	31	45	23-59	86	12	3-17	10	0	0-100	221	5	2-8	134	4	1-11	25	0	0-66	170	5	2-8	140	2	0-6
SOUTH GEORGIA MEDICAL CTR VALDOSTA GA 31603	21	24	6-47	20	30	15-57	46	7	3-21	12	0	0-99	177	3	2-9	72	10	1-15	20	0	0-79	184	10	3-10	190	1	0-5
SOUTHWEST COMMUNITY HOSP ATLANTA GA 30331	5	0	3-73	9	78	12-70	5	0	0-73	6	0	0-100	47	6	1-17	24	0	2-28	5	0	0-100	24	0	0-25	32	0	0-31
ST FRANCIS HOSP COLUMBUS GA 31995	23	13	8-48	13	31	13-62	46	9	2-19	18	0	0-97	228	5	2-8	121	2	1-12	17	0	0-97	232	9	2-8	169	0	0-6
ST JOSEPH HOSP AUGUSTA GA 30910	10	40	3-55	16	38	17-63	71	8	4-20	41	0	0-41	214	1	2-9	70	4	2-16	38	0	0-74	112	4	2-11	128	2	0-7
ST JOSEPHS HOSP SAVANNAH GA 31419	24	4	6-45	26	35	18-56	51	6	5-23	10	0	0-100	298	3	3-9	78	5	1-14	20	0	0-51	243	1	2-8	275	1	0-4
ST JOSEPHS HOSP OF ATLANTA ATLANTA GA 30342	22	9	9-50	10	20	13-68	39	13	3-23	35	0	0-48	186	2	2-9	96	1	1-13	17	0	0-75	597	6	3-7	107	1	0-7
ST MARYS HOSP OF ATHENS ATHENS GA 30601	22	14	8-49	8	63	10-70	82	9	4-17	11	0	0-98	233	5	3-10	172	6	2-11	28	0	0-92	112	7	2-11	156	2	0-6
STEPHENS CO HOSP TOCCOA GA 30577	5	20	7-78	21	38	16-57	25	4	3-30	.	.		117	5	2-11	30	7	1-23	9	0	0-99	69	9	1-13	42	0	0-18
STEWART WEBSTER HOSP RICHLAND GA 31825	2	0	0-90	1	0	3-99	1	0	0-100	.	.		14	7	1-37	3	0	0-95	.	.		5	0	0-72	3	33	0-100
SUMTER REGIONAL HOSP AMERICUS GA 31709	6	0	2-66	6	33	8-74	32	19	3-26	3	0	0-100	109	5	2-12	67	9	1-16	12	0	0-77	75	5	2-13	40	0	0-17
SYLVAN GROVE HOSP JACKSON GA 30233	3	33	2-83	2	0	4-92	4	0	0-75	.	.		14	14	0-41	3	0	0-85	.	.		29	10	1-22	6	0	0-83
TANNER MEDICAL CENTER VILL VILLA RICA GA 30180	1	0	0-97	6	67	14-81	1	0	0-100	.	.		37	5	1-19	12	0	0-43	2	0	0-100	19	5	0-30	6	0	0-95
TANNER MEMORIAL CENTER CARROLLTON GA 30117	26	8	6-43	8	25	11-70	62	3	3-19	1	0	0-100	137	2	1-9	71	4	1-14	20	0	0-98	119	3	2-10	89	1	0-9
TATTNALL MEM HOSP REIDSVILLE GA 30453	.	.		5	60	8-77	.	.		.	.		25	0	0-25	7	43	1-58	1	0	0-100	6	0	0-70	4	0	0-94
TERRELL COMMUNITY MEDICAL DAWSON GA 31742	5	40	2-71	2	50	2-90	.	.		.	.		15	0	1-35	1	0	0-98				14	0	0-39	3	0	0-99
THE MEDICAL CTR COLUMBUS GA 31901	40	23	7-40	34	32	17-51	51	10	3-21	8	0	0-98	129	7	2-11	68	4	1-15	17	0	0-99	120	8	2-10	185	1	0-6
THREE RIVERS HOSP & MEDICA MCRAE GA 31055	7	14	4-66	9	56	15-73	2	0	1-89	1	0	0-100	41	0	1-17	11	18	1-44	.	.		44	0	1-17	14	7	0-75

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
TIFT GENERAL HOSP TIFTON GA 31793	GA-171*	1446	9	6-13	75	21	13-36	39	38	15-43	34	18	8-36	40	33	11-37	46	30	23-51	31	6	5-33	106	15	11-28
TOWNS CO HOSP HIAWASSEE GA 30546	GA-172*	270	17	11-22	10	90	17-72	21	48	17-56	5	0	4-72	18	17	8-46	14	43	20-68	10	10	4-54	39	18	10-37
TURNER CO HOSP ASHBURN GA 31714	GA-173	126	16	9-22	3	67	9-91	19	37	11-50	8	0	2-56	3	33	1-81	5	40	9-79	.	.		18	17	4-39
UNION GENERAL HOSP BLAIRSVILLE GA 30512	GA-174	480	9	8-17	12	75	12-62	11	55	12-64	10	30	3-51	26	4	10-42	7	57	16-79	15	13	6-48	59	14	13-35
UNIVERSITY HOSP AUGUSTA GA 30910	GA-175*	4858	11	8-14	369	24	21-35	182	26	18-33	112	15	10-28	210	25	16-29	174	38	29-46	86	17	9-29	265	18	12-24
UPSON CO HOSP THOMASTON GA 30286	GA-176	1025	18	9-16	72	46	14-37	56	43	16-40	29	10	3-30	49	43	12-36	54	44	28-55	17	12	2-40	94	27	9-25
WALTON CO HOSP MONROE GA 30655	GA-177*	584	12	8-16	16	13	10-53	32	31	14-45	12	8	1-44	40	10	11-37	32	44	23-56	22	27	8-43	70	23	11-31
WAYNE MEMORIAL HOSP JESUP GA 31545	GA-178	822	14	8-15	31	29	12-44	34	35	16-46	7	43	4-62	48	10	11-35	31	39	20-54	44	32	9-36	88	34	10-28
WEST GEORGIA MEDICAL CENTE LA GRANGE GA 30240	GA-179*	2291	13	9-15	147	23	16-34	95	32	19-38	72	22	8-29	96	23	15-33	90	32	28-49	56	23	7-31	156	22	12-27
WEST PACES FERRY HOSP- ATLANTA GA 30327	GA-180*	1210	10	7-14	99	20	14-34	35	37	15-45	22	14	6-39	49	18	12-36	27	33	21-57	16	13	4-43	91	15	10-28
WHEELER CO HOSP GLENWOOD GA 30428	GA-181	288	15	8-18	1	0	0-98	12	58	10-58	5	40	1-68	8	0	4-59	9	44	19-77	10	10	1-50	56	16	11-34
WILLS MEMORIAL HOSP WASHINGTON GA 30673	GA-182*	400	13	9-18	14	64	6-49	30	23	13-45	2	0	0-96	34	18	10-38	9	56	17-74	17	0	6-45	59	19	11-32
WOOKSTOCK HOSP WOODSTOCK GA 30188	GA-183	156	18	9-22	3	33	4-85	4	25	3-76	4	25	1-74	5	60	6-75	6	67	17-84	7	0	1-59	36	19	9-36
WORTH COMMUNITY HOSP INC SYLVESTER GA 31791	GA-184	228	12	7-17	1	100	0-99	6	50	6-70	9	11	2-52	18	22	8-46	4	50	10-85	16	38	9-52	23	13	6-39

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
TIFT GENERAL HOSP TIFTON GA 31793	26	4	4-42	11	27	10-62	78	6	3-17	4	0	0-100	135	3	2-11	102	4	1-12	19	0	0-85	100	3	2-11	218	1	0-5
TOWNS CO HOSP HIAWASSEE GA 30546	2	0	4-93	3	67	7-88	.	.			.		29	10	2-24	8	0	1-53				35	3	1-20	9	0	0-80
TURNER CO HOSP ASHBURN GA 31714	3	100	3-83	2	0	4-92	.	.		.	.		15	0	0-37	2	0	0-92	.	.		13	8	1-39	3	0	0-91
UNION GENERAL HOSP BLAIRSVILLE GA 30512	3	0	2-82	12	8	11-61	.	.		1	0	0-100	62	2	1-14	30	10	4-30	.	.		55	2	2-16	20	0	0-46
UNIVERSITY HOSP AUGUSTA GA 30910	37	14	12-47	34	56	25-60	98	11	4-17	16	0	0-82	406	6	3-9	229	3	2-10	42	0	0-74	621	8	3-7	303	1	0-4
UPSON CO HOSP THOMASTON GA 30286	10	60	6-60	19	26	13-55	44	7	2-21	4	0	0-100	103	4	2-11	57	4	1-16	8	0	0-100	95	6	2-11	31	6	0-20
WALTON CO HOSP MONROE GA 30655	5	20	4-74	2	0	1-89	13	23	2-41	5	20	0-100	56	2	1-15	38	3	0-20	2	0	0-100	63	5	1-13	23	4	0-29
WAYNE MEMORIAL HOSP JESUP GA 31545	6	33	4-69	8	25	12-71	21	10	1-30	1	0	0-100	72	4	1-12	59	5	1-16	3	0	0-100	71	6	1-13	34	0	0-27
WEST GEORGIA MEDICAL CENTE LA GRANGE GA 30240	21	10	10-53	24	42	22-61	72	7	3-18	8	0	0-99	214	5	3-10	121	4	2-13	17	0	0-73	246	3	2-8	86	3	0-9
WEST PACES FERRY HOSP- ATLANTA GA 30327	10	30	8-63	8	50	16-76	26	15	3-29	10	0	0-100	98	4	1-11	94	2	0-13	8	0	0-97	107	6	2-10	42	2	0-17
WHEELER CO HOSP GLENWOOD GA 30428	5	20	3-72	7	57	12-75	5	0	0-69	.	.		30	13	1-23	4	0	0-78	3	0	0-100	43	0	1-17	5	0	0-100
WILLS MEMORIAL HOSP WASHINGTON GA 30673	3	33	1-82	7	29	14-78	4	0	0-76	.	.		53	2	2-18	15	0	0-41	3	0	0-100	55	0	1-15	5	0	0-98
WOOKSTOCK HOSP WOODSTOCK GA 30188	6	50	5-71	7	57	11-73	.	.		.	.		8	0	0-59	9	11	0-54	.	.		5	0	0-77	6	0	0-99
WORTH COMMUNITY HOSP INC SYLVESTER GA 31791	6	33	2-67	.	.		.	.		.			17	6	0-35	2	0	0-92	1	0	0-100	18	0	1-31	10	0	0-84

*Written Comments Not Submitted.

AMI Griffin-Spalding Hospital

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

October 8, 1987

Dear Dr. Roper:

Please find enclosed our response to the mortality information on all short term acute care Medicare patients in 1986. We have reviewed the information and appreciate the opportunity to respond.

I have found no discrepancies in the data provided. If you require any further information regarding our response, do not hesitate to contact me.

Sincerely,

Denise M. Koehler, RRA

Denise M. Koehler, RRA
Administrative Director
Health Quality and Information Services

South Eighth Street Griffin Georgia 30223 404 226 2721
P O Drawer V Griffin Georgia 30224

AMI Griffin-Spalding Hospital

Medicare provider # 110031

We, AMI Griffin-Spalding Hospital appreciate the information provided by HCFA and are pleased that our actual mortality rates are within the range of predicted mortality rates with only one exception.

In reviewing the exception of severe acute heart disease we have found that 63% of the deaths occurred within 72 hours of admission. Our population is aging and many of our patients are cared for at home. These patients are in extremely acute conditions when they arrive at the hosptial. The Quality Assurance Committee in completing mortality review has found that death was a possible, if not an expected, outcome in all cases.

We find this data useful in focusing our Quality Assurance efforts, but would caution others in using it as a basis for judging the quality of care provided by different facilities. Performing indepth peer review identifies quality problems and corrects misleading assumptions made by just a review of raw data. Meaningful qulaity of care information is a consumer right and AMI Griffin-Splading Hospital welcomes the opportunity to discuss our quality assurance process.

South Eighth Street Griffin, Georgia 30223 404 228-2721
P.O. Drawer V Griffin, Georgia 30224

Appling General Hospital-Nursing Home
Baxley, Georgia 31513
Telephone
Area 912
367-9841

TO: Health Care Financing Administration

FROM: Appling General Hospital
Provider # 11-0071

SUBJECT: Hospital Mortality Information

DATE: September 30, 1987

Appling General Hospital has completed a Review of the Hospital Mortality Information for Medicare admissions in 1986. I respectfully submit the following comments regarding this information:

1. The average age of the patients reported was 78.64 years. At this time in life, it is normally expected that many functions of the body become debilitated, thus resulting in death.

2. In every case reported, the patient had multiple medical problems. This quite naturally compounded their health problems and is a contributing factor to their expiration.

3, Eight cases in the report indicated that death occurred after discharge from the Hospital. It should be noted that 5 of these patients were returned to Nursing Homes and 3 returned home. The 3 patients who returned home all suffered from terminal cancer and preferred a death with dignity in their own familiar environment.

4. Fourteen of the cases reported had an admission of 24 hours or less. It should be noted that 8 of these cases were admissions from Nursing Homes. On arrival at the Hospital these patients were either in a comatose state or in cardiac arrest. Essentially, very little could be done to help these patients. Of the 6 remaining patients in this category, 3 were admitted with massive myocardial infarctions and 3 admitted with CPR in progress. The average age of these 14 patients was 81.46 years.

5. I fully realize that HCFA is attempting to compile meaningful information for public use and I support this concept. This information, however, does not reflect the quality of care provided to Medicare recipient nor does it take

into consideration the services that can or cannot be offered by sole community hospitals. I sincerely hope that HCFA can develop some meaningful data, but I believe that this effort falls miserably short of its intended goal.

Thank you for this opportunity to comment on the Mortality Information provided to Appling General Hospital.

Bo Smith
Administrator

MS/jp

HOSPITAL PROVIDER #110074

Athens Regional Medical Center

October 26, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

On behalf of the Hospital Authority of Clarke County and the staff of Athens Regional Medical Center, I welcome this opportunity to respond to the mortality figures released by the Healthcare Financing Administration (HCFA). Though we respect the position and duties that your office holds, we have serious reservations that the information provided in the data is misleading to the public and potentially damaging to our institution.

According to your records, our hospital's actual mortality rate is 13 percent, while the range of predicted mortality rate is 9-16 percent. If the model used to predict these figures was, in fact, valid, then we could be reassured that the public was receiving accurate information to assess our performance. However, we cannot with a clear conscience promote even the positive aspects of this data.

We believe that since the model has not been validated, and if there is a possibility that erroneous information may be provided, then it cannot and should not reflect the hospital's performance. We do believe that it can offer potential areas to focus on further review.

In addition, it also fails to reflect several key, pertinent issues that are needed to accurately assess not only our performance, but any other facility's as well.

1) Cases in which a positive outcome is not possible (such as terminal illnesses, cases with serious complications, etc.) should be excluded from the data base because the outcome was predetermined to be death. In addition, the stage of the disease should be considered in developing the model.

1199 Prince Avenue • Athens, Georgia 30613-3799 • Phone (404) 549-9977

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

2) There is no mechanism to validate the data base used for each facility by HCFA.

3) The cause of death is not reflected, only the admitting diagnosis was used for the categorization of mortalities, regardless if they occurred during or after hospitalization.

4) Nineteen percent (19%) of these deaths occurred after discharge.

You received a letter dated September 14 from Jack W. Owen, the Executive Vice President of the American Hospital Association. In the letter, Mr. Owen highlighted several concerns that we would like to echo.

1) That it is essential that HCFA preface the publication of the data with a frank discussion of both the statistical and conceptual limits of the model for making inferences about hospital quality in language that can be understood by the general public.

2) That HCFA commit itself to undertaking the necessary validation study to determine whether this statistical approach comparing mortality rates reveals anything about hospital performance.

3) Several of the methodological choices made in constructing the analysis may tend to underestimate the hospital's predicted mortality rate, which when compared with the actual mortality rate, would place the hospital under unwarranted suspicion of poor quality care, when, in fact, the difference may be due to the inability of the model to predict mortality accurately.

4) Many factors may affect the hospital's death rate - the chief of which is how ill its patients are. Severity of illness is one factor that the model by HCFA's own admission does not take into account. Other factors can also contribute to the probability of death and are equally difficult to measure and control. For example, the patient's health status, the patient's psychological condition and family support.

Again, we appreciate the opportunity to respond to your report. Should you need additional information or assistance, please do not hesitate to call on us.

Sincerely,

John A. Drew
President and Chief Executive Officer

JAD/jadz

Athens Regional Medical Center

HOSPITAL PROVIDER #110074

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Review
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir/Madam,

The following corrections need to be made to the mortality data listed for this facility. Attached are the justifications for each of the corrections.

[redacted]

The last admission for the year was 11/2/86 - 11/5/86, not 10/18/86 - 10/22/86, as your data indicates. Since the November admission's codes are in the cancer grouping, this death needs to be deleted from the ME category and placed under the CA category.

[redacted]

The PRO reviewed this record and reassigned the DRG. This coding change places this death under the UN category instead of the ME category.

NOTE: The above two corrections change our percentage under the ME category from 42% to 38% which will now be within the predicted mortality range.

[redacted]

This patient was transferred out of our facility on 12/30/86 to Emory University Hospital in Atlanta. I have verified by phone that Emory received the patient on date of transfer.

Your assistance in correcting this data is greatly appreciated. If you have any questions, or need further justification, please let me know.

Sincerely,

W. Larry Webb

W. Larry Webb
Vice-President, Fiscal Services

1199 Prince Avenue • Athens, Georgia 30613-3799 • Phone (404) 549-9977

BACON COUNTY HOSPITAL
POST OFFICE BOX 745 • ALMA, GEORGIA 31510 • 912/632-8961

October 21, 1987

Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

RE: Bacon County Hospital
Provider #110098
Hospital Mortality Information

Dear Mr. Roper:

The Bacon County Hospital has reviewed the mortality information that HCFA intends to publish in December. If the data could be used to measure quality of care, the information being released on the Bacon County Hospital shows that our internal mechanisms for assuring quality of care are apparently working well. The Bacon County Hospital does not exceed the predicted ranges in any diagnostic category and we fall on the low side of the predicted range from all causes.

Although we are very comfortable with the present data and we are not disadvantaged by the information, the implication that the data can be used to compare or compute quality of care is absurd. HCFA's admissions that the information can be very misleading and that using the information as a direct, total measure of a hospital's performance would be inappropriate, should be considered gross understatements in both cases. HCFA further admits that releasing mortality statistics is a complicated undertaking since the mortality rate at a given hospital reflects among other factors, the age, sex, diagnosis and severity of illness of patients admitted to that hospital and that these features will vary greatly among the patient populations served by individual hospitals.

Therefore, please consider this letter as one more objection to the releasing of this information under any pretention that it is the product of a sophisticated statistical analysis of data to compare or compute quality of care.

We appreciate the opportunity to submit our comments on the mortality information provided to Bacon County Hospital.

Respectfully submitted,

Jeff L. Kinlaw
Administrator

JLK/lh

Baldwin County Hospital

P. O. BOX 690
TELEPHONE 912 - 453-8441
MILLEDGEVILLE, GEORGIA 31061

AUBREY SIMPSON CHAIRMAN
ALICE F ANDREWS
PAYTON B COOK
JAMES C HOGAN SR
COMMIE R BERRY
R W McMILLAN III
LINDA SOUTHERLAND
GRADY TORRANCE

NORMAN NEDER ADMINISTRATOR

October 26, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Hospital medical staffs, hospital management, nurses and professionals in ancillary services have all committed substantial resources throughout the years to critique their performance in an effort to continue to improve their role in providing quality health care. The HCFA methodology about to be published should be recognized for its limitations, a few of which are discussed below:

1. In smaller and community hospitals, single-year data does not provide a large enough study base from which to draw any practical conclusions.
2. Mortality data, in and of itself, is not sufficient to use as a guideline for the measurement of quality.
3. Statistics, as a tool, tries to make an empirical assumption based on numbers. The practice of medicine deals with people one at a time, each presenting with unique problems and individual variances which, in our opinion, makes the measurement of quality contingent upon review of each individual case through the medical record.

In our hospital, as is true in the vast majority of hospitals in the United States, each and every death case is carefully scrutinized by numerous committees of physicians. This type of appraisal leads to rapid identification and correction of potential or actual problems.

Statistical analyses such as those published by the Health Care Financing Administration should be recognized as only one of a myriad of tools to focus the ongoing quality assurance activities taking place in America's hospitals.

Sincerely,

Norman T. Neder
Administrator

Barrow Medical Center
Winder, Georgia

Provider Number: 11-0045

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

Bleckley Memorial Hospital

408 Peacock Street • P. O. Box 536
Cochran, Georgia 31014
Phone: 912-934-6211

The data used by HCFA indicate that a total of 26 Medicare patients admitted to Bleckley Memorial Hospital died within 30 days of admission. Of these, 20 died while still a patient, while 6 died after discharge. This data was reviewed extensively by Quality Assurance and all deaths in our facility are reviewed immediately by the medical staff. In review of the HCFA data, it was found that the average age of the Medicare patient who died within 30 days of admission to our facility was 81 years. This reflects the high percentage(approximately 40%) of elderly patients who are admitted to our hospital.

In one of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. When reviewing the cases involved in this category, we found that all had previously been diagnosed as terminal in other facilities and were at Bleckley Memorial for provision of comfort close to family and friends.

Our data also reflects the closeness to our hospital of a long-term care facility that refers acute patients for final care. We are a rural facility that receives the patient who is cared for at home until the final stages of a progressive illness. These factors contribute to our high elderly and acutely ill census.

Bowdon Area Hospital

October 14, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, DC 20000

Dear Dr. Roper:

In reference to your letter of September 21, 1987 concerning the publication of selected mortality information and in review of the specific mortality statistics, I find the data in error due to incorrect coding and sequency by the Hospital in 1986.

Specifically, statistics reveal that the hospital experienced a 100% (which was one case) mortality in opthalmologic disease and renal disease respectively. In the first case, the actual cause of death was cardiac failure which was expected as the patient had myriad medical problems combined with the patient's age. In the second case, the actual cause of death was a stroke coupled with paralysis and various other medical conditions.

In factoring out the two cases, the actual mortality rate should be reduced to 4.4%. In regards to the deaths recorded in the other diagnostic categories, the cases were reviewed and found that each patient suffered from multiple secondary diagnoses which composed the primary resulting in their death.

Prior to releasing such data, the public should be made aware that the patients did not die from improper or poor quality of care but rather due to each patient's medical condition. Without sounding clicheish, information is power and when presented improperly can and will lead to disasterous outcomes. I would recommend that the data be presented in such a light that would properly explain each mortality.

Sincerely,

Alan J. Fisher
Administrator

AJF/lr

501 Mitchell Avenue ● Bowdon, Georgia 30108 ● (404)258-7207
"An Affiliate Of Alliance Health Inc."

BMH Bulloch Memorial Hospital
500 East Grady Street • Statesboro, Georgia 30458 • (912) 764-6671

William T. Richardson
Administrator

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Bulloch Memorial Hospital
Medicare Provider # 110075
Response to Preliminary Mortality Information

Dear Sirs:

We have reviewed the Hospital Mortality Information that you supplied in correspondence dated September 21, 1987. Please note the following:

(1) Patient [redacted] was seen in our hospital for a duration of less than four hours and subsequently tranferred to a hospital in Savannah. The patient subsequently expired of inner cerebral hemorrhage at another hospital.

(2) Patient [redacted] was also transferred to a Savannah hospital for cardiac catheterization and subsequent open-heart surgery. The patient subsequently died at a hospital in Savannah after only a brief (less than one day) stay at this hospital.

(3) Patient [redacted] was transferred to a hospital in Augusta, Georgia where the patient subsequently expired from complications of congestive heart failure and chronic obstructive pulmonary disease.

In summary, none of these patients expired at this hospital. According to your guidelines, they should, perhaps, be counted as patients whose

deaths are assigned to the admitting hospital rather than the transferring hospital. At least two of the cases for which durations of stay were of less than one day seem inherently unfair. I believe it should also be verified that these patients' deaths were only counted at one hospital, rather than both.

Thank you for the opportunity to comment on this information.

Sincerely yours,

William T. Richardson
Administrator

WTR/blw

Burke County Hospital 351 Liberty Street, Waynesboro, GA 30830, (404) 554-4435

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

On behalf of Burke County Hospital, I appreciate the opportunity to comment on the hospital's mortality statistics and the comparative HCFA mortality model.

The mortality information is a vital concern of the hospital and the interpretation of it should be approached with utmost care. The governing board, medical staff and management recognize that consumers have a legitimate interest in the care that is available to them. Nevertheless, we have serious reservations that the published data may be misleading and misinterpreted by the public.

In reviewing the data for Burke County Hospital, several significant problems need to be addressed. First, the column headed "Range of Predicted Mortality Rates," is simply a technical model. The HCFA data assumes that our hospital's Medicare patients are statistically similar to those specific characteristics included in the model. There is no direct measure of how ill the patient was at the time of admission nor does the model reflect this hospital's specific patient case mix. The HCFA mortality rates apply to only Medicare patients, and the overall severity of illness that affects these patients differs greatly from other patient case mixes. We have many elderly Medicare patients admitted from nursing homes and through the emergency room who have multiple admissions for persistent healthcare problems. Therefore, a predicted mortality rate for these patients is not an indication of poor quality care.

Secondly, in reviewing our hospital's specific mortality rates, the diagnostic category for cancer patients was above the predicted mortality rate. There were only five patients identified in the mortality information and four died within 30 days of admission. Because of the small sample size, it would be statistically inappropriate to extrapolate any measure of hospital performance based on these five patients. The model is better served using a larger data base.

Additionally, the medical staff has reviewed the medical records of those four patients who died within 30 days of their last admission. In all cases, the care given was deemed appropriate. Each of the four patients reviewed had been diagnosed as having terminal cancer <u>prior</u> to admission and death was considered

immanent at the time of admission. Therefore, the cause of death was not related in any way to the quality of hospital treatment.

In summary, it is important to emphasize that the HCFA data is not a measure of hospital quality performance. The reliability of the model is unknown and appears to be limited at best. The model fails to consider a wide range of factors with a significant impact on mortality. In our case, no consideration was given to the patients with cancer whose death was likely at the time of admission. The model should not be used by consumers as a guide to determine which hospitals provide quality care. Quality of care issues can only be evaluated through the process of peer review - not through simplistic statistical comparisons.

I would like to ask that these comments be published with corresponding HCFA mortality data for Burke County Hospital. If you have any questions concerning my comments please feel free to contact me at (404) 554-4435.

Sincerely,

John Nolan

John M. Nolan
Administrator
Burke County Hospital

CANDLER GENERAL HOSPITAL
AFFILIATE OF CANDLER HEALTH SERVICES

October 27, 1987

CORRECTED COPY
Correction underlined.

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We are in receipt of the Health Care Financing Administration's Hospital Specific Mortality Data for Medicare patients who died within 30 days of admission to our hospital in 1986.

In reviewing this data, we have found numerous discrepancies in dates of death and ages throughout all diagnostic categories. We have also been unable to positively verify all names, possibly due to the discrepancies in ages and deaths.

As HCFA is aware, and hopefully, the American public is becoming more aware of, an appropriate assessment of hospital performance is dependent upon many variables and requires a look at many quality indicators of which mortality is but one.

We have a quality assessment program at Candler through which we monitor all important aspects of patient care on an ongoing basis and which has mechanisms in place to identify potential concerns needing focused review (mortality review being one.)

Our Board of Trustees, Administration and Medical Staff are committed to providing the best care possible to our patients. We have always been JCAH accredited and will continue to support hospitals in their voluntary efforts toward maintaining quality.

Sincerely,

John T. Carpenter
President

/lb

5353 REYNOLDS STREET, SAVANNAH, GEORGIA (912) 354-9211
MAILING ADDRESS: P.O. BOX 9787, SAVANNAH, GEORGIA 31412-9787

OPERATED BY
CHATTOOGA COUNTY
HOSPITAL AUTHORITY
404-857-4761

CHATTOOGA COUNTY HOSPITAL
OAK VIEW NURSING HOME
SUMMERVILLE, GEORGIA 30747

BETTY WOLLSTEIN
EXECUTIVE DIRECTOR
SHIRLEY McCRICKARD
ASSISTANT ADMINISTRATOR
DIANNE FARRAR
N. H. ADM. COORDINATOR

October 21, 1987

Medicare Provider # 11-0052

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

First, we would like to correct an error in data we have provided to the survey. We have reviewed all charts for deaths related to sepis. The hospital chart lists the cause of death for patient [redacted] as due to sepsis. We believe this is an error due to premature charting of the patient's hospital record prior to the reporting of all data. The patient was admitted from a nursing home in extremis, with fever, and the impression of a sepsis. He died eight hours later, probably of multiple causes, leading to cardiopulmonary arrest, as he had fever and chest X-Ray compatible with pneumonia, and was ravaged with an old CVA with seizures. At the time of death, the chart was completed without the benefit of the results of blood cultures. A review of the chart shows that all of the cultures were subsequently reported as negative for the growth of any organisms, and it is our feeling that this death was not due to a sepsis, but represents cardiopulmonary arrest due to multiple causes as stated above.

Next, we would like to briefly discuss the use of the HCFA mortality information as an index to the quality of care provided by the hospital. We believe that the data as published, regardless of accompanying explanations will be interpreted erroneously as indicative of the quality of medical care provided by the hospital. Using the data for cancer deaths in our hospital, the implication is easily presumed as poor care for patients with cancer, and by association, possibly other illnesses. The fact is that the patient's disease (cancer) was not the reason that the patients was admitted to the hospital. A review of all patient's charts used by the HCFA in their publication revealed that every patient was admitted for the purpose of managing the patient's death, not treating his disease. In all cases, the diagnosis of cancer was established either in our hospital or elsewhere, but all treatment of the disease was provided in other facilities, and the patient only readmitted to our facility when their condition deteriorated to the extent that the management

OPERATED BY
CHATTOOGA COUNTY
HOSPITAL AUTHORITY
404-857-4761

CHATTOOGA COUNTY HOSPITAL
OAK VIEW NURSING HOME

SUMMERVILLE, GEORGIA 30747

BETTY WOLLSTEIN
EXECUTIVE DIRECTOR
SHIRLEY McCRICKARD
ASSISTANT ADMINISTRATOR
DIANNE FARRAR
N. H. ADM. COORDINATOR

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information

of death was the problem to be addressed.

In our community there is an extreme shortage of nursing home beds. Home visiting services are extremely limited, both by shortage of personnel and very restricting regulations governing use of home health services. We do not have Hospice services available, so that the community hospital assumes the role of Hospice, nursing home and home health service. A review of the chart of the patients used by the HCFA in their material, gathered for mortality information, reveals that in all cases the disease had already been diagnosed, and maximum treatment given. The patients were in the community, and were admitted to the hospital for humanitarian reasons, for management of death only. In all cases death was expected and recognized as unavoidable, the patient being admitted because there was no one else to care for them. They were at home alone with no or poor family support, or inability of those with the patient to provide adequate relief of symptoms, such as intractable pain, or persistent vomiting, or hemorrhage.

We feel that the cancer death rate of our hospital cannot be compared with another hospital treating the disease itself and that differences in hospital mortality rates reflect differences in purpose for admitting the patient to the hospital(treatment of the disease itself vs. management of death). We believe that there are many other community hospitals like ourselves performing a very necessary service that would be wrongly criticized and condemned as unsafe hospitals if the HCFA data were published for the general public information, even with every attempt to preface the material with wording that could be used by the general public in interpreting the HCFA data.

Again, we appreciate the opportunity to comment on the HCFA mortality data.

Sincerely,

H.E. Spivey,Jr. M.D.
Chief of Medical Staff

HES/sg

DENNIS K. SCHEIDT, ADMINISTRATOR
CONRAD FLOWERS, CHIEF ASSISTANT ADMINISTRATOR
J. ALAN HORTON, ASSISTANT ADMINISTRATOR

clayton general hospital

11 S.W. UPPER RIVERDALE ROAD • P. O. BOX 328 • RIVERDALE, GEORGIA 30274 • (404) 991-8000

October 26, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

We appreciate the opportunity to respond to the mortality data that H.C.F.A. plans to publish in December, 1987. Before I address the summary of our internal review, I would like to express some concerns that are common to hospitals.

1. Without giving consideration to the severity of illness for each patient, mortality statistics provide limited information.

2. The quality of care provided cannot be evaluated by the percentage of deaths within an institution.

3. Attempting to measure hospitals against each other without a severity of illness data base is unfair to the institutions and misleading to the public.

4. Thirty days to respond did not provide adequate time to permit thorough research of the data.

5. There is a concern that the responses will be released in a separate volume from the statistics thus loosening the impact of the responses.

SUMMARY OF INTERNAL FINDINGS

I. Totals

Number of deaths identified by H.C.F.A. printout	229
Number identified as never being patients at CGH	2

[redacted]

AN AFFILIATE OF SOUTHCARE MEDICAL ALLIANCE

II. Reviewed

Number of cases reviewed internally	194
Number of in-house deaths	164
Number of deaths within 30 days of discharge	30

[redacted] was identified as being admitted 12/15/86 (after discharge). Record review showed:
admitted 12/15/86 discharged 12/17/86
admitted 12/21/86 expired 12/27/86 (inpatient)

III. Breakdown

A.	Patients over 70 years of age	74%
B.	NO CODE orders patients made NO CODES on admission of after assessment and discussion with family	60%
C.	Comorbidity and complications included, COPD, ESRD.,CAD, hypertension, diabetes cancer, CVA, alzheimers	48%
D.	Patients admitted as "terminal"	52%
	cancer (primary dx or underlying)	26%
	Pneumonia	17%
	ESRD	9%
E.	Deaths within 48 hours of admission	23%
F.	Patient on ventilator	31%

Please, note that this is a "summary". Detailed information to support each case has been abstracted and is on file. It is hoped that our efforts to expand on the bare numbers will be recognized and utilized.

Please, advise if additional information is requested.

Sincerely,

Dennis K. Scheidt

Dennis K. Scheidt
Administrator

/las

Clinch Memorial Hospital

The Clinch County Hospital Authority

Homerville, Georgia

Office of the Administrator

Hospital ID Number 110094

1. [redacted]
   Admitted: 1-30-86; D/c 2-4-86. Expired in nursing home 2-28-86.
   Diagnosis: Oak Cell Carcinoma of the lung with metastatic spread to the brain, back and voluntary muscle spasms.
   Cause of death: Cardiorespiratory arrest, metastatic lung cancer.

2. [redacted]
   Admitted: 8-25-86; Expired in CMH 9-12-86.
   Diagnosis: Massive Cerebrovascular accident. Diabetes Mellitus uncontrolled insulin dependent, malignant hypertension, coronary artery disease, stress ulcer (peptic) bleeding.
   Cause of death: Cardiorespiratory arrest, large cerebral infarction, cerebrovascular accident, severe hypertension.

3. [redacted]
   Admitted: 4-29-86; Expired in CMh 5-1-86
   Diagnosis: Cerebrovascular accident, acute pulmonary edema, aspiration pneumonia, dehydration, hypoxemia, hyperglycemia and CHF.
   Cause of death: Cardiorespiratory arrest, cerebrovascular accident and bilateral pneumonia.

4. [redacted]
   Admitted: 12-4-86; Expired in CMH 12-17-86
   Diagnosis: Acute obstruction of small bowel with iteus, acute hematuria, probable pyelonephritis and cacexia electolyte imbalance.
   Patient ordered no surgery.
   Cause of death: Pneumonia, cachexia and intestinal obstruction.

5. [redacted]
   Admitted : 12-11-86; D/c 12-19-86; Expired in nursing home 12-23-86
   Diagnosis: Urinary tract infection (Klebsiella Pheumoniae), severe circulatory insufficiency, Diabetes mellitus, uncontrolled insulin dependent, hypertension.
   Cause of death: Cardiorespiratory arrest, severe peripheral circulatory insufficiency and diabetes mellitus.

6. [redacted]
   Admitted: 10-18-86; Expired in CMH 10-21-86
   Diagnosis: Atrial fibrillation, cardiac arrest, contusion of posterior chest wall, acute cystitis, hypertension.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

7. [redacted]
Admitted: 11-18-86; Expired in CMH 11-22-86
Diagnosis: Advanced myocardial degenerative disease arrest and mild pneumonia.
Cause of death: Cardiac arrest, advanced arteriosclerotic heart disease and arrhythmia.

8. [redacted]
Admitted: 12-7-86; Expired in CMH 12-26-86
Diagnosis: Advanced arteriosclerotic cariovascular disease with CHF and arrhythmia, uremia and pyrexia.
Cause of death: Advanced arteriosclerotic cardiovascular disease, congestive heart disease and arrhythmia.

9. [redacted]
Admitted : 9-10-86; Expired in CMH 9-13-86
Diagnosis: Severe dehydration, probable UTI, pre-renal azotemia, metabolic acidosis and parkinson's disease.
Cause of death: Cardiorespiratory arrest, pyelonephritis and renal failure.

10. [redacted]
Admitted: 12-18-86; Expired in CMH 12-19-86
Diagnosis: Metabolic acidosis severe with hysoxemia, renal failure CHF and cystitis.
Nine previous admissions in 1986.
Cause of death: Acute hemorrhagic cystitis, proteus mirabilis.

11. [redacted]
Admitted: 2-6-86; Expired in CMH 2-20-86
Diagnosis: Pneumonia due to psendomonas type I & II and stephylococus aurens, coma and post stroke.
Cause of death: Cardiac standstill due to pneumonia (psudomonas).

12. [redacted]
Admitted 12-6-86; Expired in CMH 12-15-86
Diagnosis: Pneumonia due to pseudomonas, CHF, pulmonary edema and dehydration.
Cause of death: Cardiorespiratory arrest.

13. [redacted]
Admitted: 10-26-86; Expired in CMH 10-27-86, fifteen hours after admission
Diagnosis: Acute excerbation of COPD with corpulmonale, left lower lobe pneumonia and hypertension.
Cause of death: Respiratory arrest, far advanced pulmonary disease, (Acute Exacerbation) chronic obstructive pulmonary disease.

14. [redacted]
Admitted 3-16-86; D/c 3-31-86; Expired at home 4-4-86
Diagnosis: Acute cystopyelitis, gastrointestinal hemorrhage, hypokalemia, atelectasis with pulmonary edema and coma.
Cause of death: Cardiac arrest, electolyte imbalance, comatose state (hypoxemia).

15. [redacted]
Admitted 7-25-86; Expired in CMH 8-4-86
Diagnosis: Acute renal failure, metabolic acidosis, uremia, colon cancer, cardiorespiratory arrest, hyperkalemia and hypertension.
Cause of death: Cardiorespiratory arrest, uremia, renal failure and terminal cancer of colon.

16. [redacted]
Admitted: 5-21-86; Expired in CMH 5-24-86
Diagnosis: Acute renal failure with severe dehydration, cardiorespiratory arrest, pulmonary edema, gastrointestinal bleeding, hyperkalemia, hyperglycemia, CHF and UTI.
Cause of death: Cardiorespiratory arrest and chronic obstructive pulmonnary disease.

17. [redacted]
Admitted: 11-2-86; D/c 11-10-86; Expired in nursing home 11-17-86.
Diagnosis: Acute renal failure with electolyte imbalance and deep coma.
Cause of death: Aspiration pneumonia, bedridden state and cachexia.

18. [redacted]
Admitted 10-31-86; Expired in CMH 11-2-86
Diagnosis: Acute renal failure, hyperkalemia, deep coma, respiratory arrest post stroke and hypertension.
Cause of death: Cardiac arrest and azotemia

19. [redacted]
Admitted: 8-25-86; Expired in CMH 8-29-86
Diagnosis: Theophyllinc toxicity, electolyte imbalance, gastrointestinal bleeding, cardiorespiratory arrest, COPD, CHF, and coronary artery disease.
Cause of death: Cardiorespiratory arrest, severe chronic obstructive pulmonary disease and gastrointestinal bleeding.

20. [redacted]
Admitted: 6-1-86; D/c 6-5-86
Diagnosis: Dysphagia secondary to scleroderma.
Cause of death: Unknown as patient was transferred to Florida-no death certificate was filed here.

21. [redacted]

Admitted: 12-30-86; Expired in CMH 12-30-86
Diagnosis: Gram negative shock due intestinal perforation. Complications metabolic acidosis and aortic aneurysm.
Patient expired appromimately 10 hours after admission.
Cause of death: Gram negative shock and perforation of intestine.

22. [redacted]

Admitted: 4-19-86; Expired in CMH 5-10-86
Diagnosis: Acute respiratory failure secondary to acute pulmonary edema, bilateral pulmonary infiltrate (E-coli), CHF, renal failure and COPD.
Cause of death: Acute respiratory arrest, acute pulmonary edema and status post myocardial infarction.

COFFEE REGIONAL HOSPITAL

West Ward Street
P.O. Box 1248
Douglas, Ga. 31533-1248
Phone: (912) 384-1900

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to your notice of the Medicare mortality data to be published in December. We would like for the following factual information to be released with any publication.

Of the 17 defined categories, Coffee Regional Hospital:

- Was below or within the predicted range for 16 categories,
- Had no deaths in 6 categories, and
- Exceed the predicted range for one category, Severe Acute Heart Disease.

Analysis of the cases in the Severe Acute Heart Disease category revealed:

- There were 19 deaths resulting in a 70% mortality rate. The predicted range was 24%-61%.
- Five of the Acute Heart Disease cases were coded following PRO's instructions. This was in error because PRO later changed this directive for this diagnosis. Coding the five cases using current PRO instructions, reassigns the five patients to the following categories:
  - Cancer (Cancer of the esophagus)
  - Metabolic/Electrolyte Disturbance (Hyperkalemia)
  - Pulmonary Disease (COPD)
  - Metabolic/Electrolyte Disturbance (Dehydration)
  - Severe Chronic Heart Disease (CHF)

The corrected mortality rate for the Severe Acute Heart Disease category is 52% which is within the predicted range of 24%-61%. With the transfer of the above five cases to other categories, Coffee Regional Hospital remains in the predicted range for each of the other categories.

Other findings include:

19 cases identified by HCFA	14 cases after corrected codes	Patient records reflected
6 out of 19 or 32%	4 out of 14 or 29%	had "Do Not Resuscitate" orders per family's request.
9 out of 19 or 47%	7 out of 14 or 50%	expired within 24 hours of admission
11 out of 19 or 58%	9 out of 14 or 57%	were over the age of 75 (two were 91)
18 out of 19 or 95%	13 out of 14 or 93%	had complications/ co-morbidities

Respectfully submitted,

Charles Hill
Administrator

CH/hg

HCA Coliseum Medical Centers

350 Hospital Drive
Macon, Georgia 31213
(912) 745-9461

The HCFA data that we have been able to verify is much more accurate than previous reports. However, we concur with HCFA's senior research Physician, Stephen F. Jenks, M. D., that "serious technical problems must be solved before we will be able to infer the quality of care from death rates . . ."

HCFA originally developed the DRG data to monitor Medicare billing, not the quality of care. The Government is using billing information to do a job it was never intended for. HCA Coliseum Medical Centers places an extremely high emphasis on quality care and mortality rates make up only one aspect of reviewing that quality care. The information in this release applies only to Medicare patients in the year 1986, which was a small percentage of patients treated at HCA Coliseum Medical Centers. We will continue to work with whatever data available to aggressively pursue providing quality care in this facility.

An Affiliate of HCA Hospital Corporation of America

Crisp County Hospital

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Re: Medicare Provider Number: 110104

Dear Dr. Roper:

Below are our comments we wished published with the mortality data you plan to release to the public in December.

Crisp County Hospital applaudes the provision of accurate information regarding hospital performance to consumers to assist them in making informed choices concerning their medical care. Unfortunately, the information released by the Healthcare Financing Administration concerning medicare patients does not, by their own admission, provide the consumer with the information required to make these choices.

Without discussing the many acknowledged methodologic difficulties with the way in which this data has been collected and analyzed, the main criticism is that it does not take into account the severity of illness of the patient when they arrive at the hospital. Severity of illness on arrival, which includes the coexistence of other complicating medical conditions, is the primary factor in determining hospital survival and is a factor over which the hospital has no control. You can not evaluate the performance of a hospital as to mortality rate unless you know the severity of illness of the patients on admission--information which released data does not provide.

Only 16 persons over age 65 died of acute heart disease at Crisp County Hospital in 1986, out of a population of approximately 20,000 patients over the age of 65 in the four county drawing area of the hospital. 1986 is the lastest year for which complete statistics are available. This record is a tribute to the effectiveness of our ambulance personnel, emergency department, cardiac care unit, nurses, physicians and support staff.

(continued)

906 5th Street North / Cordele, Georgia 31015 / 912-273-4211

Our goal is to continue, through our quality assurance programs, to maintain this high level of quality care in all phases of health care delivery. We urge the Healthcare Financing Administration to continue work already in progress to adjust mortality data on the basis of severity of illness at the time of admission. In doing so, future releases of information will more accurately reflect true quality of care and will provide patients with appropriate information on which to base their health care choices.

Sincerely,

Wayne Martin

Wayne Martin
Administrator

bl

DECATUR HOSPITAL

October 26, 1987

Dr. William L. Roper
Health Standards and Quality Bureau
Mortality Rates Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for January, 1986 through December, 1986 prior to public disclosure.

Decatur Hospital is a 120 bed acute medical surgical facility serving patients in the metro Atlanta area. We pride ourselves on providing the best care available to our patients and are pleased that the mortality statistics did not negatively reflect on our facility. The Medical Staff conducts an intensive review of the medical records of every patient who expires at this facility regarding medical management and overall care. Mortality Review and Physician Peer Review activities are an on-going process of the Quality Assurance program and an integral part of the monitoring of quality care at this hospital.

The specific mortality data reported by HCFA has been carefully reviewed by the Director of Medical records, Director of Quality Assurance, Director of Utilization Review and Administration. Our overall percentage and percentage within the individual categories fall well within the range of predicted mortality rates set by HCFA. Only in one of the reviewed categories did our mortality rates exceed 6%, while staying within the range of predicted mortality rates even though that sampling numbers were very low. While we are gratified by this external validation of our internal findings, we are ever aware that results of treatment are not only influenced by the care rendered but the seriousness of the patient's illness and general health status.

450 North Candler Street • Decatur, Georgia 30030
(404) 377-0221

The Medical Staff at Decatur Hospital will continue to review all mortality cases in an endeavor to identify opportunities to continue to meet and exceed quality care standards.

Again, thank you for the opportunity to present this response.

Sincerely,

Dewey A. Greene,
Administrator

Richard A. Parsons, M.D.
Chief of Staff

DAG/say

DE KALB GENERAL HOSPITAL

2701 NORTH DECATUR RD
DECATUR, GEORGIA 30033
404 297-2700

DE KALB MEDICAL CENTER

October 23, 1987

HEALTHCARE FINANCING ADMINISTRATION
Health Standards and Quality Bureau
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Thank you for the opportunity to review and respond to the Hospital Mortality data to be published by your organization in December. Your sensitivity to the nature and accuracy of the information is indicative of the significant effects it may have on our healthcare consumers.

We are generally concerned that this data will be used by a public not fully aware of its intent or its limitations to draw conclusions about the quality of healthcare being offered by a particular facility.

Obviously, this data alone is only an indicator and certainly not a definitive measure of the type or quality of care offered. The patients pre-hospitalization care and physical status, the method of entry into the hospital system, and the area demographics will all contribute to variances in the data.

DeKalb General Hospital, for example, receives many of its patients through an extremely active Emergency Room indicating the existence of a more acute level of disease or trauma on admission than may be present in the facility without an Emergency treatment area.

In addition, our hospital offers many specialty treatment areas for high mortality diseases that may cause the terminal patient to increase in frequency in our facility.

Demographics and pre-hospitalization treatment also play a major role in the "frequency" of death in a hospital. Many of our inner city patients arrive at the hospital in generally poor health due to economic and social conditions with virtually no pre-admission care. Those patients would appear to have a greater risk of mortality than those from upper or middle class areas with continuous medical care available.

In addition to problems seemingly inherent in the data and the forecasting model's inability to weigh all patient outcome variables, there seems to be a rather glaring implication that "the Hospital" may not be providing the quality of care generally expected based on the average

patient treated.

It is interesting that the suggestion that the Physician may also contribute to this variance is omitted from the commentary. The reference to Peer Review Organization review of this data for possible indication of a problem hints at that portion of the equation.

It would seem to be prudent to suggest that all of these short comings exist when the data is released to the public. Disclaimers will have to be many and obvious to be heard over the sensationalism that may accompany the release.

We understand the intent and effort that went into this presentation and pending release of data. We do, however, suggest that the reasonability and usability of this data as some kind of quality indicator be strongly discouraged in your release.

Again, thank you for the opportunity to comment.

Sincerely,

Bonnie L. Phipps, CPA, FHFMA
Director of Fiscal Services

October 8, 1987

Heath Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

The Dodge County Hospital verified 64 in-hospital deaths and 11 post-hospital deaths. One death that was on our data cannot be verified. Some of the dates of death were incorrect on your data. Please see attached data that is highlighted.

Sincerely,

Mary Hilliard, ART

Mary Hilliard, ART
Medical Record Dept.

Post Office Box 706 • 715 Griffin Street • Eastman, Georgia 31023 • 912/374-3491

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Donalsonville Hospital, Inc.

P.O. BOX 677
DONALSONVILLE, GEORGIA 31745
912-524-5217

October 21, 1987 PROVIDER NO. 11-0194

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

COMMENTS - HOSPITAL MORTALITY INFORMATION

Review of Medical Records on Medicare patients who expired at Donalsonville Hospital, Inc., Donalsonville, GA (or within thirty days following discharge) reveal that no deaths were due to poor quality of care but in the larger percentage of cases followed a lengthy illness. More than one third of the cases were "no code" as requested by the family and several were admitted with complications resulting from terminal cancer.

Donalsonville Hospital, Inc.
Millie Trulock
Millie W. Trulock, Administrator

Dorminy Medical Center

P.O. Box 989
Fitzgerald, Georgia 31750
(912) 423-5431

Charles Y. Davis, Administrator

MEDICARE PROVIDER # 110073

RESPONSE TO HCFA

Dorminy Medical Center
Susan Lewis or Carolyn Drexler, 423-5431
October 28, 1987

Dorminy Medical Center verifies that the HCFA data is accurate; yet administrator, Charles Y. Davis, questions its interpretation by the public.

He notes that mortality data can be appropriately used to guide or focus peer review. "But quality can only be evaluated through the peer review process - not through untested statistical comparisons." Davis says the data should be used principally for hospitals to identify or suggest areas for review.

"A mortality rate higher than predicted doesn't confirm the existence of quality problems, just as a mortality rate lower than predicted doesn't establish that the hospital provides 'high quality' care. Actual mortality rates can be higher or lower than predicted because patients treated by our hospital in some way differ from patients treated by the 'average' hospital," Davis explains.

"The HCFA data assumes that each hospital's patients are 'average' except with respect to a few characteristics included in the statistical model." For example, the model doesn't include severity of illness, whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, the patient's psychological state, general health status or prior health history.

- more -

For instance, Davis reports that Dorminy Medical Center treats a very large percentage of nursing home patients. He points out the Severe Acute Heart Disease category in which the average age of the 14 patients who died was 77. While heart disease can be treated, once it gets to a certain degree of severity, "treatment is no longer effective and the patient is ultimately going to die." In addition, Davis says this was not the first attack for five of those 14.

"To survive just one heart attack at that age is fantastic," says Davis. "In fact, in all 14 cases the patient suffered from some other complication, such as diabetes, lung disease or a previous stroke."

Davis concludes that these DMC patients differed from the "average" because "in most cases circumstances surrounding the patient's admission indicated that death was a likely outcome."

"Keep in mind that in rural areas it is not uncommon for families to care for patients at home. The patient is brought to the hospital only when death is imminent, to die in a more comfortable surrounding than is available with home care."

While Davis plans to use the HCFA data to help guide the peer review process, he explains they should not be used to confirm or contradict quality of care. He mentions that the American Hospital Association and other organizations are investigating methods of evaluating quality of hospital care, methods which rely on measures other than mortality rates.

"I look forward to the results of those efforts," Davis concludes.

Evans Memorial Hospital
200 N. River Street
Claxton, Georgia 30417

Office of Administrator
P.O. Box 518

Area Code 912
Phone 739-2611

October 16, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 2120

Dear Dr. Roper:

We applaud HCFA's efforts to recognize and correct quality problems. But we are displeased with the release of this type data to the newspaper. Taken at face value, this study cannot help people "shop" for health care. The only way to determine whether or not a death in the hospital could have been avoided is to examine each patient's medical chart to discover the individual circumstances. Each of the cases listed by HCFA have already been reviewed by our internal Utilization Review/Quality Assurance Committee's ongoing review process of deaths. We do not dispute the facts of HCFA's listings in that all of these patient's did die, but the process of identifying these "cases" does not determine fact of "wrong doing". We have an effective Quality Assurance program which continually identifies, evaluates, assesses, and resolves patient care problems. Our staff is dedicated to delivering high quality care.

Mortality rates do not say <u>why</u> a patient died. There is no way this data can reflect the actual conditions of the patients who died. We would like to point out that mortality statistics alone are not valid indicators of quality. There have been no deaths in this facility caused by poor quality of hospital care. None of these cases have been determined an avoidable death or quality problem. The data does not take into account the severity of individual patient's injury or illness. Patients in critical condition from terminal illnesses are included in the data. Some of the patients were barely alive when admitted to the hospital. Fifteen of these cases were admitted from nursing homes with terminal end-stage disease processes prior to admission, and no heroics could have altered God's intentions. Twenty four of these patients were over eighty years of age, nine were in their nineties, and thirty nine of these individual cases were over seventy. These patients are often less likely to survive serious illness. Since Medicare will not pay for patients to await death in an acute care facility unless intensity of service is met, the physician discharged some of these patients back to a nursing home to await death.

We endorse the public's right to quality of care information, but we also have a responsibility to see that the information is useful as well as reliable. More harm than good

is done when questions are raised unnecessarily about the quality of care at some hospitals. Statistics for smaller hospitals may be misleading because we have a smaller, less random data base due to the small patient population.

Although the information published applies only to Medicare, it can create a false impression of the overall quality of care at our hospital. These statistics are based simply on the number of expected deaths in our hospital! Only by knowing the full picture of what this study has both overseen and overlooked can the consumer appreciate its results. The measurement system needs to be refined. Without a more sophisticated modeling method for assessing severity of illness a hospital's actual and expected mortality rate cannot be definitely construed to reflect high or low quality of care. We will be glad to work with HCFA with further data releases, but until this system can be developed, HCFA should postpone mortality publications such as this one.

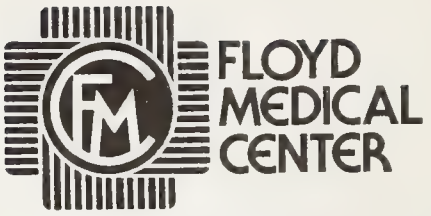
Sincerely,

Eston Price, Jr.
Administrator

EPjr/dds

Medicare ID Number is 110142

Bill G. Waters, FACHE
President



Turner McCall Blvd.
P.O. Box 233
Rome, Georgia 30161
(404) 295-5500

October 15, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Floyd Medical Center has reviewed the raw data in HCFA's mortality report and finds no substantial errors. However, Floyd Medical Center is concerned about this report. The release of this data with "normative" ranges, and "predicted" mortality, may lead the public into adopting mortality as the definitive indicator of quality of care. Determining or assessing overall quality of care is a complex process that involves looking at many variables of which mortality is but one.

For years, Floyd Medical Center has had a comprehensive quality assurance program. Eleven physician committees and all patient care related departments meet monthly and use established screening indicators to monitor quality of care. Indicators utilized include blood usage, drug usage, tissue and non-tissue review, nosocomial infections, medical record adequacy and other measures including mortality. In fact, every death occurring at Floyd Medical Center is reviewed for appropriateness of care by a quality assurance committee. All committees report to the medical staff and its officers and to the governing body of the institution to insure the effectiveness of all quality assurance functions.

Floyd Medical Center is also concerned with comparison with "average" or "predicted" mortality. Floyd Medical Center's service area nor its patient mix is "average". Floyd Medical Center serves a rural six-county area with a population of approximately 240,000.

Nearly 14% of the population is over age 65, and the per capita income level is lower than the State average and substantially lower than the national average. Numerous studies have shown that lower income groups seek access to health care at later times than those of higher income levels. The longer the delay in seeking medical attention, the more acutely ill the person will be when they finally seek care. As a result, the health status of the population served in this service area is lower than the state and national average. Also, as the major public hospital in the service area, Floyd Medical Center serves a proportionately greater percentage of low income residents who have had limited access to primary health care services. Thus, on the average, patients admitted to Floyd Medical Center have a significantly lower health status than those admitted to other area hospitals. In a service area with diminished health status, Floyd Medical Center treats the most severely ill patients.

Floyd Medical Center is a 314 bed regional referral hospital owned and operated since 1942 by the Hospital Authority of Floyd County. Floyd Medical Center offers a full range of medical, surgical, obstetrical, pediatric, psychiatric and substance abuse services on both an inpatient and outpatient basis. As the designated trauma center for Northwest Georgia, Floyd Medical Center receives the most severely ill and injured patients from throughout the region. Floyd Medical Center makes a substantial commitment of its resources each year to the provision of community services, such as free clinics, screenings, and educational programs and the operation of the family practice residency program. In fiscal year 86, Floyd Medical Center provided nearly $8,500,000 in uncompensated care (exclusive of contractual adjustments), an amount equal to over 18% of our total gross patient revenue, and accounting for over two-thirds of the total uncompensated care provided by the seven hospitals in the service area.

While Floyd Medical Center does not want to see mortality emerge as the sole indicator of quality of care, we stand committed to the provision of measurable quality of care. In fact, Floyd Medical Center was recently cited by its umbrella liability carrier which serves numerous hospitals all over the United States:

> "We wholeheartedly congratulate this hospital and the quality assurance coordinator upon the excellence of the quality assurance plan and its programs. It is one of the finest we have seen thus far."

Sincerely,

Bill G. Waters, FACHE
President

cb

GLYNN-BRUNSWICK
MEMORIAL HOSPITAL
3100 Kemble Avenue
Brunswick, Georgia 31520
Telephone (912) 264-6960

October 23, 1987

Glynn-Brunswick Memorial Hospital is a designated Rural Referral Center providing health care services to residents over a large rural and urban area. The service area includes a greater than normal percentage of persons over 55 years in age. Consequently, the hospital serves patients who have serious illnesses as well as many with numerous chronic health problems.

The HCFA mortality data indicates that there were 4,137 admissions and 244 deaths. Review of the data indicates one error. A patient listed in disease category "severe acute heart disease" was never a patient in the hospital. This changes the deaths to 243 and admissions to 4,136.

Of the 243 deaths, 36 occurred after discharge from the hospital. Analysis of these 36 deaths reveals that none were unexpected due to diagnoses such as cancer, heart condition, or pulmonary disease which were considered to be terminal. Specifically, 10 were in a nursing home, 5 were being treated by a home health agency, and one by Hospice at the time of death. The age of these 36 patients ranged from 30 - 90 with an average of 73.

Review of the aggregate data indicates an age range from 27 - 102 with an average age of 75.2 years. Although a detailed review of each death was not possible due to the time constraints for comments imposed by HCFA, it was apparent that in the cases which were reviewed, the patients were acutely ill with many disease processes other than the primary diagnosis.

GLYNN-BRUNSWICK
MEMORIAL HOSPITAL
3100 Kemble Avenue
Brunswick, Georgia 31520
Telephone (912) 264-6960

The actual mortality rate for the hospital was within HCFA's "range of predicted mortality" for all disease categories except the "severe trauma" category and, thus, the actual mortality rate was below the predicted range. It is important to note that the assignment of disease category was based on the principal diagnosis and may or may not be the actual cause of death. This can lead to misinterpretation of the mortality rate for a particular disease category.

Although this data appears to be indicative of good patient care, it must be stressed that by itself, this is not a measure of hospital performance but can be used to assist in quality assurance activities. The public should never use this data as the basis for judging the quality of care provided by this hospital or any other hospital. The Glynn-Brunswick Memorial Hospital is committed to providing quality patient care and has many functioning systems to assure that this goal is achieved.

Grady Memorial Hospital

80 Butler Street, SE, Atlanta, Georgia 30335

J.W. Pinkston, Jr.
Executive Director

Asa. G. Yancey, M.D
Medical Director

Barbara E. Bilek
Associate Director

Betty C. Blake, R.N.
Associate Director/ Director of Nursing

Darlene B. Jenkins
Associate Director

Kay S. Moses
Associate Director/ Fiscal Affairs

Robert L. Parrish, Jr.
Associate Director

Hughes Spalding Medical Center

Charles H. Wilson, Jr.
Administrator

Thomas L. Collier
Assistant Administrator

Medicare Provider #11-0079
Comments on HCFA Data
Grady Memorial Hospital
October 1987

When mortality rates alone are used to measure quality of care, they may produce a false impression of hospital treatment because they fail to consider factors which cannot be quantified, yet have a profound effect on patient outcome. A rate which appears to be out of line in a specific category may be explained when one weighs other circumstances which are not accounted for in the mortality model. Two such areas which should be taken into account when reviewing data for Grady Memorial Hospital are severity of illness and socioeconomic background of those treated. Both of these factors have a tremendous bearing on mortality rates for our hospital, but they are not reflected in the statistics. For instance, an economically disadvantaged nursing home patient may arrive at Grady mentally disoriented, totally immobile, suffering from bedsores and dying of pneumonia.

Grady is the largest hospital in the state of Georgia, providing care primarily for an indigent population in an urban setting. Our policy is to accept all patients, without regard to their ability to pay. Thus, our patient load includes a very high volume of severely ill, economically disadvantaged individuals with multiple health and social problems. This extent of illness is quite evident among patients covered under the Medicare program. Many of our patients are admitted to us from nursing homes, having been bedridden with chronic, debilitating diseases. They also present with decubitus ulcers, indwelling urinary catheters (two likely sources for overwhelming infection) and often in the final hours of their lives -- literally brought to us to die. In addition, individuals with acquired immune deficiency syndrome are representing an increasing number of our disabled patients covered by the Medicare program since our hospital operates the only state supported clinic for AIDS victims. AIDS patients also may be treated elsewhere initially but present to us in the end stages of their illness after having exhausted all of their resources. The 100 percent mortality rate in this group is reflected in our statistics.

Another observation from the data is that an extremely high percentage of patients represented in the statistics were "No Codes." A patient is classified "No Code" when a decision not to resuscitate is reached by the family, the physician, and

the patient, if possible, with support of the chaplaincy. Such a decision not to use heroic methods to prolong the dying process is made only after the patient has reached maximum hospital benefit, having received all that modern medicine has to offer for the particular disease and it is impossible to reverse the disease process.

In another problem which could skew the data, the mortality rate includes patients who died within 30 days after admission but did not die within the hospital. Many of these patients may have succumbed due to trauma or an illness which was not the cause of their admission to our hospital. Or, they may have been treated at another facility such as a nursing home prior to being sent to Grady in the end stages of their disease.

To further clarify the mortality statistics for our facility, following are observations on specific diagnostic categories in which our "actual" mortality rate met or exceeded the upper "predicted" rate:

1. Cerebrovascular Disease:
We find it curious that the HCFA statistical model revealed an expected rate of only 18-31 percent for this diagnosis. In our review of medical records of these patients, 83 percent were anticipated deaths, meaning that they had suffered a massive event and, combined with other debilitating conditions, were not expected to survive. Fifty percent of these patients were "No Code" on admission. Also, it is well known that hypertension and cerebrovascular accidents are not only more frequent in the black population (75 - 80 percent of Grady's patients are black), but that the degree of severity is greater and, as may be expected, more deaths occur. The fact that the mortality rate at Grady is not beyond the normal range supports our contention that these patients receive a high quality of care.

2. Gastrointestinal Disease:
Low income patients living in deprived environments tend to have multiple system diseases and, as a result, an overall higher mortality. Grady patients with GI disease very frequently have hypertension and hypertensive cardiovascular disease with renal involvement as well. For example, persons with GI disease who may be bleeding and have hypertension with severe arteriosclerosis are less likely to stop bleeding than a person with softer, more pliable arteries. Our review of medical records revealed a broad range of severity of illness in this category. Patients with diarrhea as a principal diagnosis were grouped with patients who had extensive esophageal cancers. These two diseases certainly will have very different expected mortality rates.

3. Urologic Disease:
In reviewing medical records of patients in this category, it

is noted that in 67 percent of the cases, death was anticipated. Thirty-three percent of these patients were "No Code." Forty-two percent had indwelling Foley catheters, a common source of urinary tract infection. Sixty-seven percent of these patients that presented with gross urinary tract infections had been sent to us from nursing homes. Again, patients from disadvantaged groups tend to report to the hospital at a more advanced stage of their illness. This severity is not reflected in HCFA's data.

4. Pulmonary disease:
Despite patient education efforts, studies show that persons with less income and formal education use tobacco products more frequently than individuals from more affluent backgrounds. Nevertheless, tobacco abuse is not considered a "complication" in the HCFA model, but it certainly should be listed as one. Tobacco use exacerbates such chronic diseases as asthma and emphysema (COPD). It also plays a large role in development of lung cancer and infections such as pneumonia, the most common Medicare diagnosis at our hospital. Patients in a debilitated condition are much more susceptible to community acquired lung infections like pneumonia. Our review of medical records of these patients revealed advanced pneumonias (bilobar and bilateral) in a majority of cases. Forty-eight percent of the patients were from nursing homes. Death was anticipated in 76 percent of the cases, despite initiation of antibiotic therapy. Forty-three percent of these individuals were "No Code."

5. Sepsis:
In reviewing death records in this category, we found that 92 percent of the patients had either decubitus ulcers, an indwelling urinary catheter (two likely sources of infection) or were declared "No Code" on admission. The tendency of our disadvantaged patients to neglect their health cannot be over emphasized. These individuals clearly presented in advanced state of infection -- too late for therapy to be beneficial.

GWINNETT HOSPITAL SYSTEM

GWINNETT COUNTY, GEORGIA

Post Office Box 348 Lawrenceville, Georgia 30246 404/995-4321

Franklin M. Rinker
President

October 23, 1987

TO: William L. Roper, M.D.
Administrator
Health Care Financing Administration

FROM: J. Thomas Karr, Jr.
Vice President
Gwinnett Hospital System

RE: Response to HCFA mortality rate information

All mortality rates for Medicare patients treated within the Gwinnett Hospital System in 1986 are within the range of mortalities predicted by HCFA for each category.

In reviewing the information provided by HCFA, the following data differences were discovered:

1. Five cases on the HCFA list were never seen within Gwinnett Hospital System.
2. Two cases classified as in-hospital deaths were out-of-hospital deaths.
3. Seven cases classified as out-of-hospital deaths were in-hospital deaths.
4. Some age and date discrepancies existed.

A more detailed breakdown of these discrepancies is attached.

Since mortalities must be reviewed on an individual basis in order to assess quality, all patient mortalities within Gwinnett Hospital System, not only Medicare patient mortalities, are reviewed on an on-going basis by our medical staff. When reviewing these cases, the physicians consider all medical facets of the case as well as the overall general health of the patient, the stage of the illness at the time of admission, the psychological condition of the patient and the family support of the patient.

In addition to this on-going mortality review, all of the cases identified in the current HCFA information on mortality rates were again reviewed by our quality assurance staff.

This mortality review is only one part of an active quality assurance program in place at Gwinnett Hospital System. This program monitors all aspects of patient care to assess quality for all patients with all types of admissions.

Quality of care is of utmost concern to everyone from our on-line employees, through the medical staff to the administration and the board of trustees.

As a not-for-profit hospital governed by a locally-appointed board of trustees who are members of our community, we are dedicated to providing quality care to all members of our community. We are proud of the full range of acute care services we make available to local residents and we are especially proud of our on-going quality assurance program.

bsh

A. Never treated in 1986 (5)

1. [redacted] CA 96 F 5/17-5/24 5/24/86
2. HS 78 F 10/2-10/4 10/4/86
3. PN 75 M 5/13-5/15 5/15/86
4. UN 85 F 1/18-2/12 2/12/86
5. UN 90 F 10/3-10/15 10/22/86

B. Treated but dates incorrect:

1. [redacted] CA 81 (82) M 3/10-3/11/86
   died 3/11/86 (not 3/10/86)

C. Reported by HCFA as hospital death but our records show an out of hospital death.

1. [redacted] HS 70 M 5/15-5/26
   died 5/27 (not 5/26/86)
2. [redacted] SE 73 M 6/29-7/03 transferred to VA Atlanta &
   died 7/28 or 7/29 in V.A. Hospital

D. Reported by HCFA as out of hospital death but our records show in-hospital death.

1. [redacted] HM 61 F 6/2-6/27 died 6/27/86
2. GI 79 M 1/9-1/10 died 1/10/87
3. UN 73 F 10/30-11/10 died 11/10/86
4. CA 73 M 12/6-12/22 died 12/22/86
5. GU 92 F 9/6-9/12 died 9/12/86
6. ME 77 M 1/8-1/9 died 1/9/87
7. UN 44 F 1/1-1/2 died 1/2/87

E. Still alive > 30 days after D/C. NONE

F. Ages different than what is reported in our records:

1. [redacted] CA 81 (our records show 82)
2. GI 82 (our records show 80)
3. HS 74 (our records show 72)
4. HS 69 (our records show 71)
5. PN 75 (our records show 74)
6. RN 79 (our records show 80)
7. UN 82 (our records show 72)
8. UN 76 (our records show 78)
9. HS 91 (our records show 89)
10. SE 73 (our records show 74)

MORTALITY REVIEW SUMMARY

DIAGNOSTIC CATEGORIES	Deaths Reported by HCFA IN HOSP.	Deaths Reported by HCFA POST HOSP.	Deaths Verified by Hospital IN HOSP.	Deaths Verified by Hospital POST HOSP.	Deaths/unable to verify POST HOSP.	No Record of Patient
HIGH RISK						
Cancer	26	7	26	3	3	1
Stroke	15	1	15	1	---	0
Severe acute heart	26	0	24	1	---	1
Severe chronic heart	18	2	19	0	1	0
GI catastrophies	6	2	6	2	---	0
Metabolic/electrolyte	1	3	2	2	---	0
Pulmonary	27	10	26	5	5	1
Renal	2	1	2	0	1	0
Sepsis	6	1	5	1	1	0
Severe Trauma	3	0	3	0	---	0
LOW RISK						
Ophthalmologic	0	0	0	0	---	NA
Gynecologic	0	0	0	0	---	NA
Low risk heart	2	3	2	2	1	0
Gastrointestinal	7	3	8	2	---	0
Urologic	3	5	4	2	2	0
Orthopedic conditions	1	0	1	0	---	0
All Other (UN)	24	12	25	6	3	2
TOTAL--All Categories	167	50	168	27	17	5
TOTAL	217		212			5

HAMILTON HEALTH CARE SYSTEM INC

POST OFFICE BOX 1900
DALTON GEORGIA 30722-1900
(404) 226-3003

October 26, 1987

Dear Dr. Roper

Hamilton Medical Center appreciates the opportunity to review and respond to the 1986 Medicare mortality data published by the Health Care Finance Administration. We have reviewed the data and have found only minor discrepancies between our own records and those of HCFA.

Because we fall within the predicted ranges of the diagnoses cited by HCFA, we have chosen not to comment on specific cases. While we do not dispute the data, we believe there are several factors not contained in the report that have an impact on our mortality experience:

- Since 1984, Hamilton Medical Center has been designated a rural referral center by Medicare which means we receive many of the most seriously ill and injured patients from a three-county region of North Georgia;

- In 1983 we initiated the first Medicare-approved Hospice program in the state of Georgia, the 35th in the nation. This growing program of comprehensive care for the terminally ill attracts patients from a three-county region. These are all patients for whom death is the expected outcome;

- The expressed wishes of increasing numbers of patients for whom death is the expected outcome that extraordinary life sustaining measures not be taken is a contributing factor;

- Transfer of dying patients from nearby nursing homes to Hamilton Medical Center also affects our mortality experience.

The Health Care Financing Administration is correct to insist that mortality data alone are insufficient criteria for judging hospital quality, as they do not take into account such factors as patient mix and severity of illness.

The quality and appropriateness of patient care is continuously monitored as a part of our Quality Assurance program. All patient deaths are reviewed by physicians utilizing clinically valid criteria --particularly severity of illness and any complicating factors-- as a part of that process. As a result, we are confident that the quality of patient care rendered at Hamilton Medical Center is appropriate.

The Medical Center is a 257 bed, public, not-for-profit institution that operates under a system of voluntary governance. As a regional referral center, our range of services is diverse and includes a Level II special care nursery, concentrated and intensive care units, a Level II trauma center, a voluntary adult psychiatric unit, radiation and medical cancer treatment programs and a hospice program for the terminally ill. As a public hospital, we provide care to all regardless of ability to pay. In 1986, approximately 24 percent of the care we provided was uncompensated.

Again, Dr. Roper, we appreciate this valuable opportunity to respond to HCFA's mortality data. From the community hospital to the Health Care Financing Administration, we are unified in our efforts to provide quality health care to all who seek it.

Sincerely

N. Burkett

Norman D. Burkett, President
Hamilton Health Care System, Inc.

Hart County Hospital

The Heart of the Community

Gibson and Cade Streets • P.O. Box 280 • Hartwell, Georgia 30643 • (404) 376-3921

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Re: HCFA Mortality Release Date
Hart County Hospital Medicare
Provider Number 110059

Gentleman:

Hart County Hospital (HCH) is a small rural facility staffed by a small core of University and Medical Center trained specialists in Family Practice, Internal Medicine, General and Gynecologic Surgery, Urologic Surgery and Orthopedic Surgery. All surgeons are distinguished by respective American Board of Specialty Certification; and ALL MAJOR SURGERY IS PERFORMED BY FULLY TRAINED AND AMERICAN BOARD CERTIFIED SURGEONS. Anesthesia is provided by Certified Registered Nurse Anesthetists. Radiology and Pathology services are provided by external groups. Within well-recognized bounds of capabilities, the Hart County Hospital provides basic medical and surgical care that is second to none: bigger buildings do not house more competent staffs nor provide more successful treatments. Patients with medical and surgical problems of unusual complexity or of a nature which requires other specialty expertise are referred to appropriate specialists at appropriate institutions.

The intent of the HCFA in publishing these figures is presumed of good faith, but some of the results are severely misleading.

For example, of the 11 cancer deaths: all were terminally ill and were admitted solely for supportive care; only one had received primary treatment at Hart County Hospital and that one in the remote past, with effective surgical palliation of an incurable disease; no means to prolong suffering were used; only one patient underwent operation to alleviate the agony of bowel obstruction. On the other hand, the six recorded Medicare patients receiving primary care for high-risk cancer at HCH during this period recovered uneventfully and survived, easily calculated to be a 0% MORTALITY RATE IN HIGH-RISK CANCER CARE.

For example, the HCH demonstrates superb skills in managing LOW-RISK HEART DISEASE (0% MORTALITY). On the other hand, patients requiring more invasive diagnostic and treatment modalities are routinely referred to tertiary medical centers unless by reason

Continued...

pre-existing serious medical problems (and in agreement among responsible next of kin) or unless precarious instability renders transfer hazardous. Under these circumstances, the mortality rate as calculated by HCFA methodology is expected to be high. Similar considerations apply to the Diagnostic Category; "severe renal disease." Another way, HCH retains essentially only those patients in these Diagnostic Categories who are admitted solely for supportive care and other patients with complex problems referred elsewhere for specialty therapy: any survival within these groups is highly commendable.

The remaining figures are extremely favorable, and appear to SUBSTANTIATE THAT HCH PROVIDES ONLY THE HIGHEST QUALITY OF MEDICAL AND SURGICAL CARE FOR ITS COMMUNITY.

J S Cacchioli

L. G. Cacchioli, M. D., Chairman
Hart County Hospital
Medical Quality and Appropriateness Review Committee

LGC:mdm

HCA Palmyra Medical Centers

COMMENTS ON THE HCFA MORTALITY DATA
HCA Palmyra Medical Centers
Albany, Georgia

Data Verification

The data used by HCFA indicate that a total of 138 Medicare patients admitted to HCA Palmyra Medical Centers died within 30 days of admission. Of these, 101 died while still a patient of the hospital, while 37 died after discharge. Our own records indicate that 1,940 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients reported by HCFA as being treated at HCA Palmyra Medical Centers is correct. In addition, our records indicate that 3 of the patients listed as expiring outside of the hospital actually expired while still an inpatient. In one of these patients, the last admission in 1986 was not recorded; thus, changing the diagnostic category and the place of death. Two patients had incorrect dates of expiration. One patient was assigned to the principal diagnosis of 588.9 instead of 558.9, which resulted in placing the patient in a different diagnostic category.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in HCFA's analysis.

The attached reports demonstrate the aforementioned corrections.

Results of Preliminary Medicare Record Review

The statistical model utilized by HCFA measured the relationship between a limited number of patient characteristics and risk of death. This model, however, fails to consider a wide range of factors that significantly impact the patients' outcomes. Examples are the patients' overall health status on admission to the hospital and the stage of the patients' illnesses. The severity of illness on admission was indicative of a death outcome in 51% of the 138 patients admitted. Furthermore, in another 25% death was not expected at the time of admission but became a significant possibility because of the patients' change in condition and their stage of illness. Of the 37 patients that were dismissed from the hospital alive, all were in the terminal stages of their disease processes. The HCFA model is also misleading since it is based on the reason that necessitated the

2000 Palmyra Road
PO Box 1908
Albany Georgia 31703
Telephone (912) 888-3800
A Subsidiary of HCA The Healthcare Company

patients' admission to the hospital (principal diagnosis) and not the cause of death.

Hospital = 110163 HCA Palmyra Medical Centers Albany GA

CORRECTED REPORT

Diagnostic Category	Cases	Actual Mortality Rate	Range of Predicted Mortality Rates
All Causes	1,317	10 %	7 to 14 %
CA - Cancer	108	20 %	15 to 35 %
CE - Cerebrovascular Accidents	59	32 %	18 to 41 %
EY - Ophthalmologic Disease	11	0 %	0 to 94 %
GC - Gastrointestinal Catastrophes	45	18 %	7 to 31 %
GI - Gastrointestinal Disease	168	4 %	2 to 9 %
GU - Urologic Disease	102	1 %	1 to 12 %
GY - Gynecologic Disease	10	0 %	0 to 100 %
HL - Low-Risk Heart Disease	50	12 %	2 to 16 %
HM - Severe Chronic Heart Disease	39	27 %	12 to 39 %
HS - Severe Acute Heart Disease	29	41 %	20 to 55 %
ME - Metabolic/Electrolyte Disturbances	13	15 %	4 to 47 %
OP - Orthopedic Disorders	151	0 %	0 to 6 %
PN - Pulmonary Disease	88	25 %	11 to 29 %
RN - Renal Disease	12	8 %	6 to 57 %
SE - Sepsis	3	33 %	6 to 87 %
TR - Severe Trauma	54	9 %	3 to 21 %

GA 76.2

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	18	4	18	4
CE -- Cerebrovascular Accidents	16	3	16	3
GC -- Gastrointestinal Catastrophes	6	2	5	3
GI -- Gastrointestinal Disease	2	3	4	2
GU -- Urologic Disease	1	0	1	0
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	3	3	3	3
HM -- Severe Chronic Heart Disease	5	4	6	4
HS -- Severe Acute Heart Disease	11	1	11	1
ME -- Metabolic/Electrolyte Disturbances	1	1	1	1
OP -- Orthopedic Disorders	0	0	0	0
PN -- Pulmonary Disease	14	8	14	8
RN -- Renal Disease	2	0	1	0
SE -- Sepsis	1	1	1	0
TR -- Severe Trauma	3	2	3	2
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	16	7	17	6
Total -- All Categories	99	39	101	37



HENRY GENERAL HOSPITAL

1133 Hudson Bridge Road
Stockbridge, Georgia 30281-5099

404-389-2200

JOSEPH G. BRUM
ADMINISTRATOR

G. SAM AHERN
ASSISTANT ADMINISTRATOR

HENRY GENERAL HOSPITAL

COMMENTS IN RESPONSE TO
PUBLICATION OF SELECTED MORTALITY INFORMATION

Henry General Hospital appreciates the opportunity to analyze and respond to the selected mortality information that HCFA plans to publish in December, 1987.

We agree with HCFA that this information, on its own, is not a complete measure of the quality of care at an individual hospital, and we agree with HCFA's recommendation against the use of this information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals.

We are appreciative of any additional insight that this data may provide as to the quality of patient care, and we will incorporate valid statistical indicators from the HCFA methodology into our Peer Review process. Clear, well-defined indicators serve as guides for the focus of ongoing hospital Peer Review activities that have long been in place and are continually reviewed, upgraded, and enhanced.

After reviewing the information specific to Henry General Hospital, it is our understanding that the analysis of our data did not reveal any quality problems based upon this methodology. We would note here that through our internal hospital Quality Assurance/Peer Review process, each death noted in the study that occurred in Henry General Hospital had been reviewed by the hospital Mortality and Morbidity Review Committee.

Mortality Review, however, is only one of several important components of a comprehensive Quality Assurance program. Many other Quality Assurance review activities, too lengthy to enumerate in this brief commentary, are performed on a concurrent and ongoing basis in our hospital. These activities will continue within the scope of our Quality Assurance/Peer Review program, and it is our distinct goal to promote and enhance these programs at every opportunity.

mls
10/27/87

Humana Hospital
Gwinnett

October 23, 1987

William L. Roper, MD
The Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided late last month. Humana Hospital - Gwinnett supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

Our Hospital's quality assurance program includes regular and complete review of all admissions which result in patient mortality and morbidity. The information is made available to our medical staff so that opportunities to improve care can be acted on.

The most serious limitation of the HCFA model is that is has not been validated. Deviations from the predicted rate could indicate some problem with quality; but, it could also reflect the exclusion from the model of significant factors in influencing risk of death. Since these raw numbers reflect deaths which occurred in a limited segment of a hospital's patient population (the elderly) and are not adjusted for many of the factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

Our Hospital's quality assurance staff has reviewed the data. Since some deaths occurred outside the Hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent (with some exceptions) with our Hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis.

In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

Specifically, we reviewed all categories and find that all seventy-seven 77 patients who were attributed to Humana Hospital - Gwinnett were in fact treated in our facility during 1986. We confirmed sixty-three (63) deaths by our records. Three (3) mortalities reported to occur outside of the facility actually occurred inhouse. These are [redacted]. In all three cases the date of death reported is in error.

Four (4) patients were reported as being younger than our records indicate. In three (3) cases, the principle diagnosis stated does not agree with our records.

In eleven (11) of the fourteen (14) cases of mortality occurring outside of our facility, the medical record contained documentation of poor prognosis in patients suffering from chronic and/or terminal disease. The remaining three (3) were aged 70, 86, and 95, and had a history of chronic disease.

Though our facility fell within the predicted range in every category, we are cautious in attaching significance to this as a measure of quality care. Rather the information will be used to identify or suggest areas for review by the medical staff.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our Hospital will do everything possible to assist our staff and our community in understanding how this data can best be used to improve health care services.

Sincerely,

David L. Harris

David L. Harris
Executive Director

DLH/jd

960 Joe Frank Harris Parkway
P O Box 1006
Cartersville Georgia
30120
Telephone 404 382-1530

Humana Hospital
Cartersville

October 22, 1987

William L. Roper, M.D., Administrator
Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I welcome the opportunity to comment on the hospital specific mortality data provided to us last month. Humana Hospital-Cartersville supports the Healthcare Financing Administration's desire to educate those interested in Medicare quality issues. Although this program is early in its developmental stages, and the measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, peer review, and utilization review, as well as complete outside review by the Joint Commission on Accreditation of Healthcare Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of the hospital's patient population (the elderly), and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While the data is useful in its current format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers and be cautioned about drawing any conclusions from the data regarding the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and to provide information to physicians and staff members which may be useful in treating future patients. This review is an important component of our existing quality assurance program.

As you have pointed out, this mortality data can and should be used to identify areas for additional peer review but is not a measure of hospital performance.

Our hospital quality assurance committee and medical staff have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this component of the data. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

There are certain hospital specific factors that impact this data and should be considered in the evaluation process. This community currently experiences a significant and documented shortage of nursing home beds which often leads to patients with chronic degenerative conditions being admitted to the hospital shortly before death with little hope for recovery. Also, this facility experiences 55% of all inpatient admissions directly through the emergency room indicating high severity of illness characteristics for many patients. In addition, the fact that Humana Hospital-Cartersville is a sole community provider with the nearest neighboring hospital being 25 miles away serves to negatively impact the mortality data.

All categories were reviewed, and I offer the following comments related to the renal disease and cancer categories:

- Renal Disease - The computed mortality rate of 80% compares with the predicted range of 5% to 75%. However, the size of the statistical sample must be questioned in that only 5 total cases fell into this category for all of 1986. The average age of the patients in this category is 81 years. Three of the four patients who ultimately died were in such a condition upon admission that the families in consultation with the doctor decided that heroic lifesaving measures would not be appropriate, and as a result "Do Not Resuscitate" orders were written. Revising the data to account for these patients would place the hospital well within the predicted range of this category.

- Cancer - The computed mortality rate of 50% compares with the predicted range in this category of 10% to 44%. The average age of the patients in this category is 79 years. Investigation of these charts revealed that 8 of the 13 patients were admitted for terminal care with eminent death expected by the physician and family. For example, 4 of these patients arrived in the emergency room, 3 comatose and in almose full respiratory arrest, and in each case the patient expired within 2 hours. Again, revising the data to allow for these patients would place the hospital within the predicted mortality range of this category.

I appreciate the opportunity to comment on these statistics and hope that the additional information provided will be helpful in attempting to refine the collection and reporting of raw hospital data.

Sincerely,

Keith Sandlin
Executive Director

Medicare Provider # 110030

COMMENTS ON THE HCFA MORTALITY DATA
Hutcheson Medical Center, Fort Oglethorpe, Georgia
Hospital #110004

The actual mortality rate for Hutcheson Medical Center falls outside of the range of HCFA's predicted mortality rate in one of the diagnostic categories, Severe Acute Heart Disease. HCFA's data identifies 62 deaths in this category. The 62 death records were reviewed, and the results of this review are included in these comments. Fifty-nine of the patients died while still hospitalized, and 3 died after discharge.

Out of a total of 62 patient deaths, 21 patients were classified as "no codes" with death as the probable outcome. The ages of these patients ranged from 61 to 94. Two of the 21 patients were admitted from nursing homes; and 6 of the 21 patients were admitted to Hutcheson Medical Center in full cardiopulmonary arrest through the Emergency Medical System or the Emergency Department.

Fourteen of the remaining 62 patients had records showing physician documentation, indicating a "poor outcome" for these patients' hospitalizations. The age range of these patients was 55 to 88. Two of these 14 patients were admitted from nursing homes, and 1 was admitted from another acute care hospital. Out of those 14 patients, 10 were admitted in full cardiopulmonary arrest.

Eleven of the remaining 62 patients were placed on ventilators for periods of time ranging from 1 to 16 days.

Nine of the 62 patients had temporary pace makers, and all efforts were exhausted to prevent their deaths.

Two of the 62 patients had diagnoses of extensive cancer along with Severe Acute Heart Disease.

One patient had a large inferior and lateral wall Myocardial Infarction. According to documentation, this patient's family refused all extra measures and requested only that the patient be kept comfortable.

One of the 62 patients was a [redacted] admitted with a drug overdose. This patient had known coronary artery disease and upon heart catheterization, his right coronary artery, circumflex and left anterior descending arteries were found to be occluded. The patient was given streptokinase and placed on a balloon pump. All efforts were exhausted in the care of this patient.

The remaining three patients were dismissed alive from the hospital and died subsequently. One of these patients was dismissed at his insistence, and it was documented in the physician's progress notes that this patient "is non-compliant with diet and does as he wants to do." One of these patients was dismissed with a diagnosis of end stage renal disease.

As part of the Quality Assessment program at Hutcheson Medical Center, all hospital deaths are reviewed monthly. The mortality rate for calendar year 1986 was 3.45%. This compares favorably to the even lower 1987 year-to-date rate of 2.5%.

Jeff Davis Hospital

Telephone 375-7781 P. O. Box 1200 1215 South Tallahassee Street Hazlehurst, Georgia 31539

October 26, 1987

Department of Health and Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Re: Mortality Rates

Dear Sir:

We have reviewed all 44 records and 26 of these records had been reviewed by the local PRO with no quality issues being cited on any of the 26 records. We would infer these were normal deaths that could not have been prevented.

We disagree with using unproven statistical analyses as a judgment of quality of care for hospitals. We feel this is an additional burden on small rural facilities without justification or purpose.

We strongly believe the money wasted on statistical garbage could be better spent by paying for patient's necessary medical care.

Sincerely,

James G. Peak,
Administrator

JGP/bp

HOSPITAL = 110049 JEFF DAVIS HOSP HAZLEHURST GA

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	338	13 %	8 TO 18 %
CA - CANCER	11	64 %	18 TO 71 %
CE - CEREBROVASCULAR ACCIDENTS	11	27 %	10 TO 61 %
GC - GASTROINTESTINAL CATASTROPHES	13	8 %	4 TO 46 %
GI - GASTROINTESTINAL DISEASE	42	0 %	0 TO 16 %
GU - UROLOGIC DISEASE	11	27 %	1 TO 45 %
GY - GYNECOLOGIC DISEASE	1	0 %	0 TO 100 %
HL - LOW-RISK HEART DISEASE	22	5 %	0 TO 26 %
HM - SEVERE CHRONIC HEART DISEASE	21	33 %	9 TO 44 %
HS - SEVERE ACUTE HEART DISEASE	9	67 %	13 TO 69 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	16	6 %	4 TO 43 %
OP - ORTHOPEDIC DISORDERS	6	0 %	0 TO 100 %
PN - PULMONARY DISEASE	68	19 %	11 TO 31 %
RN - RENAL DISEASE	4	25 %	2 TO 76 %
SE - SEPSIS	1	0 %	0 TO 97 %
TR - SEVERE TRAUMA	1	0 %	0 TO 100 %

The # of cases which left after was in our hosp.

divide the # of deaths by the # of cases from Column 6 CASES.

Predictions from 1986 totals

KENNESTONE HOSPITAL

677 Church Street
Marietta, Georgia 30060
(404) 426-2000

October 27, 1987

COMMENTS ON THE HCFA MORTALITY DATA
FROM KENNESTONE HOSPITAL

Data Verification

The data used by HCFA indicates that a total of 363 Medicare patients admitted to Kennestone Hospital died within 30 days of admission. Of these 300 died while still a patient of the hospital, while 63 died after discharge. Our records indicate a difference in the number of Medicare admissions that occured in 1986 than the HCFA data represents. Presumably this discrepancy reflects multiple admissions of individual beneficiaries. Our records also indicate that of the 300 Medicare patients who died within 30 days of admission while still an inpatient, 3 were still alive at the time of discharge. It is impossible to determine the percentage of the 63 patients who presumably died after discharge who may in fact still be alive, as information concerning death after discharge is not included in patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used, in your analysis.

In all of the diagnostic categories, our hospital's actual mortality rate is within the predicted mortality rate. However, these numbers are subject to question in our opinion. The significance of being within the predicted mortality rate is not easily understandable for some of the following reasons:

-Diagnostic groups are reflective of the reason the patient was admitted to the hospital, not the reason for death. These calculations do not identify why patients died.

-Mortality rates are affected by the patient population a hospital serves. In our case we have regional trauma and oncology units. These services attract a larger volume of patients from a broader geographic area than the "average" hospital and these type patients have a higher than average risk of death.

-Severity of illness of a patient at the time of admission to a hospital is a major factor affecting probability of death in a particular case. The HCFA data does not reflect severity of illness in its calculations.

The absence of these factors in the mortality calculations may render erroneous and misleading results or interpretations. We agree with HCFA that this data is not a measure of hospital performance. Under no circumstances should the data be used as the basis for judging the quality of care provided by different hospitals.

Our mortality rates for all patients were compared to the Medicare data, and as expected, the overall rates are lower. Our quality assurance staff have analyzed the HCFA data and have identified the following errors:

Cancer Category [redacted]
Patient did not die - was readmitted to the hospital on 3/21/87.

Renal Disease Category [redacted]
Did not expire - had been seen as an outpatient 5/20/87.

Unknown Category [redacted]
Did not expire - seen in ER 34 times since discharge.

Three patients were identified that transferred to other hospitals prior to death:

Severe Chronic Heart Disease Category [redacted]
Transferred to VA hospital.

Sepsis Category [redacted]
Transferred to VA hospital.

Severe Acute Heart Disease Category [redacted]
Transferred to another general hospital.

Detailed analysis of cases are attached.

Quality of care is of the utmost concern to our hospital's governing board, management and medical staff. Our facilities' efforts are directed at ensuring the provisions of high quality care. Mortality and other outcome data are a part of our institution's comprehensive quality assurance program in which all deaths are evaluated through the process of peer review. The value of this quality assessment method is our ability to identify remediable deficiencies in patient care for which corrective action can be taken. The HCFA-released mortality data did not identify any trend of deficiencies in patient care and does not identify areas in which any hospital provided "high" quality or "low" quality care.

Individual peer review of the Medicare deaths reported in 1986 revealed that appropriate diagnostic, therapeutic, or supportive measures were provided at our facility and of the 300 patients that died while hospitalized, 207 cases were "No Codes". In many cases death was an expected outcome at the time of admission. No hospital should use aggregate numbers as a measure of care; neither can Medicare billing data tell the public about hospital quality.

We concur that data to better measure quality of care is needed for institutions and the public, and we support the efforts of AHA, JCAH, and other organizations who are investigating methods of evaluating hospital quality that rely on multiple measures including mortality rates. Our institution looks forward to the results of those efforts.

Thank you for the opportunity afforded us to review and respond to the HCFA data prior to release.

Janice Belcher

Janice Belcher, R.N.
Director, Quality Management

Hospital #110035

Enclosure

DIAGNOSTIC CATEGORY	# CASES	# DEATHS	MORTALITY RATE	FINDINGS — KENNESTONE HOSPITAL, page 1
A-Cancer	241	75 listed; corrected #: 74	31% listed; corrected rate 30.7%	1 error found - 254092802A Anderson Patient did not die: Readmitted to hospital 3/21/87. 30 patients over age 75. 14 patients expired within 3 days, an additional 20 patients expired within 7 days. 1 Transferred here from another hospital. 40 patients had Metastatic Carcinoma. 59 patients were "No Code" status. 18 patients expired after discharge, in 15 death was expected. 6 patients went home. 5 patients went with Home Health and/or Hospice. 7 patients went to Nursing Homes. 3 died within 3 days of discharge. 10 died more than 7 days after discharge.
E-Cerebrovascular Accidents	190	44	23%	27 patients over age 75. 17 patients expired within 3 days, 9 more within 7 days. Other contributing factors included cancer, seizures, cardiac and pulmonary disease. 5 patients came from Nursing Homes. 32 patients were "No Code" status. 5 patients expired after discharge. Death was an expected possibility for all [illegible], or these patients transferred to Nursing Homes.
Y-Ophthalmologic Disease	12	0	0%	
GC-Gastrointestinal Catastrophes	80	10	13%	5 patients over age 70. 3 patients expired within 3 days, 4 more within 7 days. 6 patients had Small Bowel Obstructions. Other significant secondary diagnoses were 4 with Metastatic Cancer and Sepsis. 5 were "No Code" status.

GA 97.2

GNOSTIC CATEGORY	CASES	# DEATHS	MORTALITY RATE	FINDINGS
Gastrointestinal Disease	329	13 cases	4%	8 patients were over age 70. 5 patients expired within 3 days, 3 more within 7 days. 1 patient transferred from another hospital. Contributing factors: 5 patients had Metastatic Cancer, 2 with Sepsis, 2 with renal failure. 5 patients were "No Code" Status. 2 patients died after discharge - both were "No Codes". 1 had Hospice follow-up.
Urologic Disease	176	7 cases	4%	All patients were over age 75. 2 patients came from Nursing Homes and 1 from another hospital 1 patient expired within 24 hours. 2 patients were "No Code" status and 1 patient was a "Limited Code". 3 patients transferred to Nursing Homes on discharge and expired within 7 days - in 2 cases death was expected possibility due to secondary diagnoses. Pertinent secondary conditions included Cancer, Gangrene, Heart failure, and Pneumonia.
Gynecologic Disease	49	1 case	2%	Age: 66 LOS: 16 days From Nursing Home "No Code" Status Dx: Fistula Vagina and Bowel, Congestive heart failure, and Cardiopulmonary arrest.
Low-Risk Heart Disease	269	7 cases	3%	All cases over age 70. 1 case from Nursing Home. 2 patients expired within 3 days. Other contributing factors included Cancer, Emphysema, significant cardiac disease. 1 patient was "No Code" Status. 3 patients were transferred to Nursing Homes with death being expected. 1 patient expired within 3 days due to Metastatic Cancer.
Severe Chronic Heart Disease	103	25 cases	24%	16 patients over age 75. 1 case from Nursing Home and 1 from Boarding Home. 8 expired within 3 days, 4 within 7 days. Significant secondary diagnoses were: Cancer, stroke, pneumonia, COPD, Myocardopathy and renal failure.

GA 97.3

DIAGNOSTIC CATEGORY	# CASES	# DEATHS	MORTALITY RATE	FINDINGS — KENNESTONE HOSPITAL, page 3
HM-Severe Chronic Heart Disease, continued				13 were "No Code" Status. 5 patients expired after discharge, 1 transferred to a VA Hospital, 2 to Nursing Homes with death being an expected possibility, and 1 home with Home Health. (Transfer to VA Hospital #213188302A, Long)
HS-Severe Acute Heart Disease	90	38 cases	42%	28 cases over age 70. 20 expired within 3 days, an additional 7 within 7 days. 33 cases were Myocardial Infarctions and 3 cases were Ruptured Aortic Aneurysms. Pertinent other contributing factors included 8 with Cardiogenic Shock, 4 with Cancer, and 7 with either CHF or pulmonary edema. 10 cases were "No Code" Status. 2 were "Limited Code" Status. 1 patient was transferred to another hospital and expired that day (#252149156A, Name: Hale) 2 cases were discharged home and expired within 3 days.
ME-Metabolic/Electrolyte Disturbances	41	1 case	2%	Age: 85 Dx: Severe dehydration, Cardiac Arrest LOS: 9 days
OP-Orthopedics Disorders	356	6 listed; corrected #5	2%; corrected 1.4%	1 Coding error found- #255266722A, Evans - No orthopedic Dx identified - Patient's Dx included CHF, ASHD, Malfunctioning Mitral Valve Prosthesis, Cerebral Embolism and Bacterial Endocarditis. 4 patient's over age 75. 2 expired within 3 days. 1 patient came from a hospital and 1 patient from a Nursing Home. 2 patients had Pathological Fractures. Significant secondary diagnoses included Metastatic Cancer, Congestive heart failure, & COPD. 2 patients were "No Code" status. 1 patient transferred to a Nursing Home and expired within 2 days.
PN-Pulmonary Disease	273	38 cases	14%	20 patients over age 75. 1 Transferred from another hospital and 4 were from Nursing Homes. 11 Expired within 3 days and 6 within 7 days. Other pertinent contributing factors were diagnoses including Cancer (6), Chronic Lung Disease (10), CHF (7), Renal Failure (7), and Respiratory Failure (4).

GA 974

GNOSTIC CATEGORY	CASES	# DEATHS	MORTALITY RATE	FINDINGS
Gastrointestinal Disease	329	13 cases	4%	8 patients were over age 70. 5 patients expired within 3 days, 3 more within 7 days. 1 patient transferred from another hospital. Contributing factors: 5 patients had Metastatic Cancer, 2 with Sepsis, 2 with renal failure. 5 patients were "No Code" Status. 2 patients died after discharge - both were "No Codes". 1 had Hospice follow-up.
Urologic Disease	176	7 cases	4%	All patients were over age 75. 2 patients came from Nursing Homes and 1 from another hospital 1 patient expired within 24 hours. 2 patients were "No Code" status and 1 patient was a "Limited Code". 3 patients transferred to Nursing Homes on discharge and expired within 7 days - in 2 cases death was expected possibility due to secondary diagnoses. Pertinent secondary conditions included Cancer, Gangrene, Heart failure, and Pneumonia.
Gynecologic Disease	49	1 case	2%	Age: 66 LOS: 16 days From Nursing Home "No Code" Status Dx: Fistula Vagina and Bowel, Congestive heart failure, and Cardiopulmonary arrest.
Low-Risk Heart Disease	269	7 cases	3%	All cases over age 70. 1 case from Nursing Home. 2 patients expired within 3 days. Other contributing factors included Cancer, Emphysema, significant cardiac disease. 1 patient was "No Code" Status. 3 patients were transferred to Nursing Homes with death being expected. 1 patient expired within 3 days due to Metastatic Cancer.
Severe Chronic Heart Disease	103	25 cases	24%	16 patients over age 75. 1 case from Nursing Home and 1 from Boarding Home. 8 expired within 3 days, 4 within 7 days. Significant secondary diagnoses were: Cancer, stroke, pneumonia, COPD, Myocardopathy and renal failure.

GA 97.3

DIAGNOSTIC CATEGORY	# CASES	# DEATHS	MORTALITY RATE	FINDINGS
HM-Severe Chronic Heart Disease, continued				13 were "No Code" Status. 5 patients expired after discharge, 1 transferred to a VA Hospital, 2 to Nursing Homes with death being an expected possibility, and 1 home with Home Health. (Transfer to VA Hospital #213188302A, Long)
HS-Severe Acute Heart Disease	90	38 cases	42%	28 cases over age 70. 20 expired within 3 days, an additional 7 within 7 days. 33 cases were Myocardial Infarctions and 3 cases were Ruptured Aortic Aneurysms. Pertinent other contributing factors included 8 with Cardiogenic Shock, 4 with Cancer, and 7 with either CHF or pulmonary edema. 10 cases were "No Code" Status. 2 were "Limited Code" Status. 1 patient was transferred to another hospital and expired that day (#25214915bA, Name: Hale 2 cases were discharged home and expired within 3 days.
ME-Metabolic/Electrolyte Disturbances	41	1 case	2%	Age: 85 Dx: Severe dehydration, Cardiac Arrest LOS: 9 days
OP-Orthopedics Disorders	356	6 listed; corrected #5	2%; corrected 1.4%	1 Coding error found- #2552bb722A, Evans - No orthopedic Dx identified - Patient's Dx included CHF, CSHD, Malfunctioning Mitral Valve Prosthesis, Cerebral Embolism and Bacterial Endocarditis. 4 patient's over age 75. 2 expired within 3 days. 1 patient came from a Hospital and 1 patient from a Nursing Home. 2 patients had Pathological Fractures. Significant secondary diagnoses included Metastatic Cancer, Congestive heart failure, & CO[illegible]. 2 patients were "No Code" status. 1 patient transferred to a Nursing Home and expired within 2 days.
PN-Pulmonary Disease	273	38 cases	14%	20 patients over age 75. 1 Transferred from another hospital and 4 were from Nursing Homes. 11 Expired within 3 days and 6 within 7 days. Other pertinent contributing factors were diagnoses including Cancer (6), Chronic Lung Disease (10), CHF (7), Renal Failure (7), and Respiratory Failure (4).

DIAGNOSTIC CATEGORY	# CASES	# DEATHS	MORTALITY RATE	FINDINGS
PN-Pulmonary Disease, contigued				24 patients were "No Code" Status. 3 patients transferred to Nursing Homes and 1 to a Boarding Home. All 4 had poor prognoses due to secondary problems. [1 patient, #256164786A, Blackwell, expired in the hospital on 1/8/87 (patient was re-admitted 12/31/86).]
RN-Renal Disease	35 cases	6 listed; correct #5	17%, corrected rate: 14%	1 error: #252224533A, Hawkin, did not expire on 6/3/86 - patient has been seen as an outpatient 5/20/87 at Kennestone. 4 cases over age 75. 1 expired within 1 day, 3 within 7 days. Significant secondary diagnoses included Lymphoma, CHF, and Sepsis. 2 were "No Code" Status and 1 "Limited Code" Status.
SE-Sepsis	23	11	48%	9 were over age 70. 5 Expired within 3 days, 1 more within 7 days. 2 patients came from Nursing Homes. Other contributing factors included CHF, Pneumonia, Renal Failure, Leukemia, and Chronic Lung Disease. 8 cases were "No Code" status and 1 "Limited Code" Status. 1 patient transferred to the VA Hospital and the other patient who went home with Home Health follow-up had a poor prognosis. (Transfer to VA Hospital #259014509A, Reith)
TR- Severe Trauma	114	10	9%	7 patients were over age 85. 3 patients came from Nursing Homes, and 1 from another hospital. 1 patient expired within 1 day, another within 5 days. Significant secondary diagnoses included Heart Failure, Pneumonia, Renal Failure, and Pulmonary Embolus. 5 patients were "No Code" Status. 2 patients were sent to Nursing Homes - 1 expired within 1 day.

GA 975

DIAGNOSTIC CATEGORY	CASES	# DEATHS	MORTALITY RATE	FINDINGS
UN-Unknown		74 listed; corrected #: 73		1 error: #254145361A, Wilson, patient did not die-has been seen in the ER 34 times since discharge on 8/14/86. 1 error in date of death listed on #2570343978, Garrett, patient expired 1/27/86 not 1/24/86. 34 cases over age 75. 11 Expired within 3 days, and 10 more within 7 days. 4 patients came from other hospitals and 3 from Nursing Homes. 19 had the principal Dx of Respiratory Failure, 2 with Bronchitis, 1 Pulmonary PB, 2 with Cerebral Hematoma, 2 with Carotid Occlusion, Cerebral Aneurysm, 2 with Clotted Vascular Access grafts, 1 with Cancer, 1 with Urinary Retention, 1 with GI complication, 5 with Cardiogenic or Septic Shock, 1 with Blunt Trauma, 1 with Atrial Fib, 1 with Aortic Stenosis, and 1 with Atrial Septal Defect. Question why these type diagnosis were not incorporated in some of the other categories listed. Significant secondary Dx included: 23 with Chronic Lung Disease, 15 with Cancer, 6 with Pneumonia, 13 with Renal Failure, 7 with Bronchitis, 5 with CVA's, 5 with Respiratory failure. 38 were "No Code" Status. 1 was "Limited Code" Status. Death was expected for 12 of the 15 patients who expired after discharge. 10 of these patients were transferred to Nursing Homes, and 8 of these expired within 7 days.

KENNESTONE HOSPITAL
at Windy Hill

2540 Windy Hill Road
Marietta, Georgia 30067
(404) 951-3100

October 26, 1987

COMMENTS ON THE HFCA MORTALITY DATA
KENNESTONE HOSPITAL AT WINDY HILL
MARIETTA, GEORGIA 30067

DATA VERIFICATION:

Twenty-eight cases reviewed. One case was invalid. HFCA states patient admitted 12/8/86, discharged 12/16/86, date of death 1/3/87. Patient was, in fact, admitted 12/24/86 and expired in-house 1/3/87. Therefore, 27 cases were reviewed.

Another change in data - HFCA indicates that a patient was admitted 2/18/86, discharged 3/14/86, date of death 3/10/86; patient expired 3/14/86.

Ten HFCA diagnostic categories were changed after review of records. Please note changes on the attached.

Review indicated that appropriate diagnoses, treatment, and supportive measures were provided in all cases.

It should be noted that the HFCA data are not all-inclusive. The mortality rates reported in gross aggregate data by DRG are not an indicator of quality of care a facility provides.

John Richards
Administrator

A DIVISION OF THE KENNESTONE REGIONAL HEALTH CARE SYSTEM
"Professionally We Serve, Personally We Care"

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

MORTALITY REVIEW SUMMARY

DIAGNOSTIC CATEGORIES	"Cases" Reported by HCFA	"Cases" Verified by Hospital	Deaths Reported by HCFA	Deaths Verified by Hospital	In-hospital Deaths	Post-discharge Deaths	Cases Requiring Further Review
HIGH RISK							
Cancer	4	5	4	5	5	0	0
Stroke	1	1	1	1	1	0	0
Severe acute heart	1	3	1	3	3	0	0
Severe chronic heart	3	2	3	2	2	0	0
GI catastrophies	1	2	1	2	2	0	0
Metabolic/electrolyte	0	0	0	0	0	0	0
Pulmonary	6	3	6	3	3	3	0
Renal	0	2	0	2	2	0	0
Sepsis	1	1	1	1	1	1	0
Severe Trauma	0	1	0	1	1	0	0
LOW RISK							
Ophthalmologic	0	0	0	0	0	0	0
Gynecologic	0	0	0	0	0	0	0
Low risk heart	1	0	1	0	0	0	0
Gastrointestinal	1	1	1	1	1	1	0
Urologic	0	0	0	0	0	0	0
Orthopedic conditions	2	0	2	0	0	0	0
unknown	7	6	7	6	0	6	0

LANIER PARK
HOSPITAL

PROVIDER NUMBER: 110188

Response and Comment
to Mortality Data Released by
Health Care Financing Administration

I. Identification and correction of errors.

Seven errors were identified in the HCFA data relating to actual dates of admission, discharge and death. This represents a 6.3 percent margin of error. The corrected dates are shown in Appendix A. However, these corrected dates do not change the outcome of the reported data.

II. Supplemental statistics requiring interpretation.

Of the reported 111 Medicare deaths, twenty-four (24) or twenty-two (22) percent were post-discharge deaths or deaths occurring within 30 days of admission.

To attribute a patient's death to an individual hospital based solely on the fact that the patient died within 30 days of the last hospital admission does not measure quality of care provided in that facility or by the patient's attending physician.

These deaths may have resulted from patient characteristics that were not measured or events unrelated to hospitalization (e.g., car accidents following discharge.) For such data to become more meaningful, quality measures must extend beyond the hospital setting.

III. Influence of hospital patient mix.

Lanier Park Hospital serves as a regional referral center for northeast Georgia. Patients admitted to Lanier Park usually have been ill for some time or have been transferred from other facilities; therefore, the hospital's patient mix is generally a more acute patient, which is especially true for Medicare patients.

P.O. Box 1354
675 White Sulphur Road
Gainesville, Georgia 30505
Telephone (404) 531-2300

An Affiliate of
HEALTHTRUST
INC. The Hospital Company

Most Medicare patients have multiple co-morbid or complicating conditions that would be contributing causes of death. For example, a Medicare patient admitted for pneumonia might also have terminal cancer or chronic lung disease, both of which would impact their life expectancy.

In sum, the course of an illness is affected by a number of different circumstances, many of which have little to do with the care rendered in the hospital setting.

APPENDIX A

* Corrected

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LTRS)	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH
[redacted]	[redacted]	07/28/86	08/01/86	08/04/86
				* 08/05/86
[redacted]	[redacted]	07/03/86	07/11/86	07/12/86
			* 07/12/86	
[redacted]	[redacted]	08/06/86	08/07/86	08/06/86
			* 08/06/86	
[redacted]	[redacted]	10/21/86	10/24/86	10/31/86
				* 10/24/86
[redacted]	[redacted]	02/05/86	02/10/86	02/19/86
				* 02/18/86
[redacted]	[redacted]	01/04/86	01/08/86	01/08/86
				* 01/09/86
[redacted]	[redacted]	01/29/86	02/03/86	02/28/86
				* 02/14/86

GA 100.2

LSMH
Louis Smith Memorial Hospital
POST OFFICE BOX 306 / LAKELAND, GEORGIA 31635 / (912) 482-3110

STATEMENT

At Louis Smith Memorial Hospital all deaths are reviewed by the Quality Assurance Committee as part of our ongoing Quality Assurance Program.

Of the 31 Medicare patients included in the mortality data, 28 expired at Louis Smith Memorial Hospital and 3 expired outside the facility after being discharge in a stable condition.

All deaths were within the predicted mortality range for their particular diagnosis group. Twenty-five of the cases were in high risk diagnosis groups. The remaining two cases which were in low risk diagnosis groups were patients who had multiple diagnoses complicating their condition and were contributing factors in their deaths.

All deaths were felt to have been unpreventable and patients received quality medical care.

Marion Memorial Hospital

Another
Basic
American
Medical
Company

MEDICARE PROVIDER #110133

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

In responding to the information regarding review of mortality in our facility for 1986, I note that a couple of points should be mentioned.

1) I think we fare extremely well in view of the fact that our actual overall mortality rate is 11% whereas the range of predicted mortality is 9-22%, thereby showing that our facility has an actual mortality rate in the low range of what you would predict from your figures.

2) There were two areas in which you show us with a 100% mortality rate, that being the Cancer and Severe Acute Heart Disease. On reviewing the charts involved in this it is certainly noted that the two (2) cases of Cancer who succumbed were victims of end-stage terminal cases. I think if the individual charts are reviewed by you, you will see that the facts speak for themselves as to proper care having been rendered in these cases. Secondly, in the area of Severe Acute Heart Disease, again these two (2) death that were noted were severe and sudden in nature. Again, this is a limited study in a small hospital and thereby the statistical distribution in this case turned out to be 100% mortality in those areas. However, note that the expected mortality in CA was up to 91% and of Severe Acute Heart Disease, up to 94%. Therefore, even statistically, with a small sample of this, this is not a significant statistical deviation.

Overall, I think it should be viewed by anyone viewing these statistics that these figures are in a small rural acute care hospital and that the actual mix of patients will vary because of the limited sampling. Additionally, any patients in these type categories who had a chance of a better outcome, were generally provided that chance by referral to an appropriate consulting facility for more definitive care. This is particularly marked out by the fact that the two (2) cancer deaths were in particular, expected and during the time of their hospitalization, palliative and supportive care was really the goal of treatment as opposed to any expectation of cure or improvement.

HIGHWAY 41 NORTH
BUENA VISTA, GEORGIA 31803
PHONE (912) 649-2331

Marion Memorial Hospital

Another
Basic
American
Medical
Company

Again, should anyone view this data, they should certainly be aware of the total context within which it is presented and to make any kind of valid distinction as to what this means, would certainly need to review the particular institution, its goals, its capabilities and the type of referral pattern of the facility.

Sincerely,

James R. Hagler, M.D.
Chief of Staff
Marion Memorial Hospital

JRH;sgc

HIGHWAY 41 NORTH
BUENA VISTA, GEORGIA 31803
PHONE (912) 649-2331

Medical Center of Central Georgia

777 Hemlock Street P.O. Box 6000 Macon, Georgia 31208 (912) 744-1450

Damon D. King, F.A.C.H.E.
Administrator

October 26, 1987

William L. Roper, M.D.
Administrator, HCFA
Hubert H. Humphrey Building, Room 314-G
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Roper:

Please join this letter with the one you received from our hospital dated October 23, 1987 and signed by Richard W. Turner. You should have received the above letter on October 26, 1987.

We wish to have the attached enclosures included as a part of our comments on the 1986 HCFA Mortality Data and published in total when the mortality data is released publicly in December. This is extremely important since the attached documents clearly document the acute deficiency involved in the mortality data because of the lack of measurement of the severity of illnesses of any given patient. Further, the enclosed documents clearly indicate the severe problem involved in using this material to in any way measure quality performance in any given institution. Your own staff acknowledges the profound problems associated with the gathering and publication of the mortality data. In the case of our hospital, a classic example of how flawed the mortality data remains is demonstrated by the fact we had two patients reported as hospital deaths when both left the hospital alive.

We appreciate very much your cooperation in letting our hospital and other hospitals across the country comment on this material before it is published and allowing our comments to be included as a part of the published data.

Sincerely,

Damon D. King, FACHE
President

encl. (1) AHA News Special Report October 5, 1987
(2) AHA News October 19, 1987
(3) AHA News Viewpoints September 21, 1987
(4) DHHS Letter dated September 2, 1987
(5) October 23, 1987 letter to Dr. Roper

AHA News

American Hospital Association | Vol.23 No.39 | October 5, 1987

Special Report

HCFA mortality data improved but still lack illness-severity links

Although HCFA Administrator William L. Roper, M.D., worked closely with the hospital industry to make this year's release of mortality data more palatable to providers and more meaningful to consumers, health care experts warn that the data remain flawed.



Roper

Most glaringly, HCFA death rates do not adequately account for severity of illness, a prerequisite to meaningful mortality statistics, according to the AHA.

"Almost everyone agrees that a severity-of-illness adjustment would rectify a host of shortcomings in Medicare, and this is one of them," said Jack W. Owen, the AHA's executive vice president in Washington, DC.

He said Congress ordered HHS to complete a severity-of-illness adjustment study by October 1988 to help to determine whether hospitals qualify for payment adjustments under PPS.

"But it's a lot tougher to apply a severity adjustment to gauge quality than to gauge cost," Owen said.

For now — and for the near future — no comprehensive severity-of-illness measure exists.

In a recent New England Journal of Medicine article, Stephen F. Jencks, M.D., HCFA's senior research physician, wrote that even though "case-mix adjustment lies at the heart of both [PPS] and recent proposals for outcome-oriented quality surveillance," there is no acceptable measure at this time.

And despite the need, "[s]erious technical problems must be solved before we will be able to infer the quality of care from death rates or

(continued on page 5)

HCFA mortality-data debate enters round 2

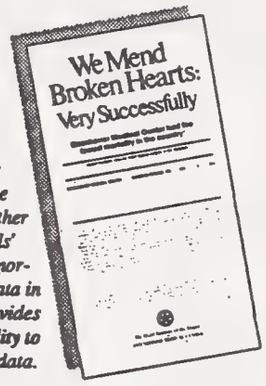
(continued from page 1)

other outcome measures," he wrote.

Part of the problem is a lack of data. Jencks noted that Medicare collects only a uniform hospital discharge data set that includes a patient's age, sex, discharge status and discharge diagnosis as well as the types of procedures performed.

More data, taken from medical records and perhaps other sources, will be needed, Jencks told AHA News late last week.

HCFA's most recent data compare projected mortality rates to actual rates for Medicare patients who died within 30 days of admission. Last year, almost half of the 710,000 Medicare-beneficiary deaths in the nation's 6,000 acute care, short-stay facilities occurred within 30 days of admission.



Experts disagree on whether hospitals' use of mortality data in ads provides credibility to flawed data.

But in the absence of a realistic severity-of-illness measure, "how do hospitals show in a convincing way that the differential [between projected and actual mortality data] may not have to do with quality but with having sicker patients?" asked Gail R. Wilensky, a health care economist for Project HOPE.

"That is the bugaboo of DRGs," she said.

Wilensky, who belonged to a HCFA mortality-data advisory group that included AHA President Carol M. McCarthy, also cited another flaw in the data.

"There's no reason to assume that problems associated with mortality are also related to non-mortality problems," she said. Such "non-mortality problems" could include hospital-acquired infections or readmissions.

"If I were a hospital in real trouble, I might want to show we're doing well on other quality of care measures related to non-mortality," Wilensky said.

And what if a hospital's death rate is lower than expected?

Wilensky said she saw "no danger" in a facility advertising "what a wonderful hospital it is" as long as the practice blends well with the mores of the community.

But hospital leaders, including the AHA, disagree.

"You can't just say at one point that the data is raw and at another point use it to your advantage," said a spokesman for the Nashville, TN-based Hospital Corporation of America.

The AHA, meanwhile, encourages hospital executives to tell consumers how hospitals ensure high-quality care and to explain the circumstances affecting individual HCFA mortality rates.

But the association warns hospital officials not to share mortality rates with the public before the data's official release in December.

"If hospitals break the agreement and go public, their credibility with HCFA will be broken," said the AHA's Owen.

— Suzan Bibisi

AHA: 'HCFA must not waver on the essential fact that the data do not measure hospital performance'



McCarthy

The hospital-specific mortality data that HCFA will release this December will be prefaced by a "Joint Statement of Interested Parties." AHA President Carol M. McCarthy recently sent a letter to HCFA Administrator William L. Roper, M.D., commenting on a draft of the statement. Here is part of what she said:

The AHA believes this statement to be an extremely important aspect of the planned [data] disclosure to the general public, for most will take their direction as to the meaning and appropriate use of the data from this statement. It must be accurate if the damage that will flow from uninformed interpretation or misuse of the information is to be avoided.

Our principal concern is that the current statement fails to squarely and unequivocally set forth the limitations of the data. At a minimum, the preface should emphasize that the [HCFA] model measures the effects of age, sex, certain co-morbidities and other specified factors on the mortality rates of hospitalized patients — nothing more. The remaining unexplained variation may result from the patient characteristics that are unmeasured, events unrelated to hospitalization (e.g., car accidents following discharge) and pure statistical chance, as well as from hospital and physician performance.

Put otherwise, the identification of an outlier is no more than an indicator of *possible* quality problems. It cannot even suggest that quality problems are *probable*, let alone *confirm* quality problems.

It is not helpful to [Medicare] beneficiaries for the preface to equivocate about the usefulness of the data for consumers. Consumers should not be led to believe that the analysis can help them to make judgments about the quality of a hospital's care, when the model's ability to predict the presence or absence of quality problems has not been tested, let alone validated. A beneficiary interested in the data should discuss them with his or her physician and a hospital representative but should be clearly advised not to use the data to draw conclusions about hospital performance.

The [HCFA] model undoubtedly does validly measure the relationship between a limited set of patient characteristics and the risk of death. With regard to hospital performance, it is no more than a screening tool for use in clinical and management review.

A number of wording changes would result in a statement that takes into account these serious concerns. [But] it is important that HCFA not waver on the essential point: The data are not "measures" of hospital performance and should not be used by consumers to make inferences about hospital quality.

HCFA mortality data 'must not become an end in themselves'

Jack W. Owen



The long process governing this year's release to the public of hospital-specific Medicare mortality data is nearing closure. Any day now, hospitals will receive from HCFA their actual and predicted mortality rates — overall and for 16 specific diagnoses.

The release is the federal government's second stab at responding to increasing business, public, government — and, yes, even hospital — demand for valid indicators of health care quality. The aftershocks of last year's hasty, poorly managed disclosure of mortality rates in response to media pressure still reverberate. Press accounts ranged from sensational to balanced, and what will probably be a binding precedent for disclosure has been set. In today's highly competitive health care marketplace, openness and consumer education are catchwords.

This year's release promises to be different. Media sensationalism is less likely the second time around. And the AHA has negotiated long and hard with HCFA to ensure that the event is handled professionally and that the disclosed data are as meaningful as possible. Most important, under our agreement with HCFA, every hospital will have 30 days to review and to comment on the data before HCFA releases it to the public. If those data don't compare favorably with predicted norms, hospitals can explain why, and the disclaimers will accompany the data when they're released.

Make no mistake, HCFA's predicted mortality rates aren't perfect. Even HCFA Administrator William Roper, M.D., acknowledges that "a difference between a hospital's actual and expected mortality rates cannot be definitely construed as reflecting especially high or low quality of care."

HCFA's model does take into account patients' age, sex, previous hospitalizations, and both primary and secondary diagnoses. But all-important variations in severity of illness and patients' socioeconomic factors still aren't part of the calculations.

It's these variables that hospitals must be prepared to address during their 30-day comment periods. Hospitals with reputations for high-quality care tend to attract the most seriously ill patients, and we can't let that catch-22 go unexplained. Teaching hospitals, tertiary care and referral centers, and institutions serving large numbers of low-income or medically indigent patients must explain why they might have high mortality rates.

Potential patients must be told they can't assume — as HCFA's model does — that differences between predicted and actual performances reflect inappropriate hospital behavior. Rather, they must be made aware that HCFA's model doesn't account for many factors beyond hospitals' control, which affect patient outcomes and hospital performance. Hospitals must step in where HCFA falls short, and they must make sure that data disclosure doesn't provoke unnecessary apprehension.

Likewise, hospitals whose mortality rates are lower than expected should respect HCFA's 30-day comment period and not break the embargo on release of the information. That period was granted so that hospitals will have time to fashion reasoned responses to HCFA's data. If even a few hospitals break the agreement and go public, our credibility will be broken, too.

Even more important, mortality data can't be allowed to become an end in themselves. The AHA understands their use — with due-process protections — to signal PROs to look more closely. And hospitals themselves want meaningful mortality data to measure performance.

But that data shouldn't signal consumers or large purchasers to shop elsewhere. Great care must be taken not to brand high-mortality-rate hospitals inferior when the opposite is more likely true. Otherwise, consumers will make ill-advised decisions, and consumer-education efforts will be set back rather than advanced.

Ultimately, the potential damage to providers' reputations and the confusion among beneficiaries that could result from use of invalid measures of quality demands improved quality yardsticks.

Jack W. Owen is the AHA's executive vice president in Washington, DC.

The chronically disabled elderly's LTC needs are not 'a bottomless pit'

Letters

Rather than quick fixes, it is increas-

GA 107.3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

Damon D. King
Administrator
Medical Center of Central Georgia
777 Hemlock Street
P.O. Box 6000
Macon, Georgia 31208

SEP 2 1987

Dear Mr. King:

This is in response to your July 29 letter to Thomas G. Morford regarding the mortality listings for your facility for the diagnosis related groups (DRG) 127 and 336. I apologize for the delay in my response.

The first concern you mention was the mislabeling of DRG 127 in some publications. We recognize that Congestive Heart Failure is not the correct title for DRG 127, Heart Failure and Shock. The use of this diagnosis for the title of the DRG may well have come from a misunderstanding based on the fact that our aggregate data showed that 98 percent of all cases which fell into DRG 127 had a principal diagnosis of Congestive Heart Failure. The statistics published were based on analysis of the data for all cases in DRG 127, not just those with Congestive Heart Failure as the principal diagnosis.

Your other concern about DRG 127 also related to DRG 336 and involved inaccurate data. The numbers that HCFA used to compute the statistics came from one of two sources. If the hospital submitted its Medicare bills in electronic form to the fiscal intermediary (FI), then the mistakes in data entry took place at the hospital. If the hospital submitted their bills to the FI in paper form, the mistakes in data entry took place either at the FI, or the FI transferred the numbers from the paper form submitted by the hospital.

Unfortunately, we are unable to control this type of data error; however, the mortality lists were not designed to be definitive statements about the quality of care at a given facility. The mortality listings were developed as a screening device for Peer Review Organizations (PRO) to use in focusing their review of potential quality problems. The PROs were to take the data and perform specific analysis of each hospital before any conclusions were drawn. These lists were not designed for public use, but were subsequently released because of requests made under the Freedom of Information Act.

The Health Care Financing Administration is very concerned that the next hospital mortality information release is appropriate and useful to the public, hospital managers and PROs. Many steps are being taken to achieve that end. Numerous meetings and discussions have been held with statisticians, health services researchers and clinicians from the private sector to discuss the proposed methodology for creating the list and to receive their recommendations. The methodology was published in the Federal Register to explain the process, the methodology, and seek additional comment. A copy of the notice is enclosed. Additionally, in September, each hospital will receive information which is the basis for its statistics, to enable the hospital to conduct its own analysis and provide comments. These comments will be included in the public release of the listing in December.

If you have further questions, please do not hesitate to contact me.

Sincerely yours,

Richard H. Husk
Director
Office of Medical Review
Health Standards and Quality Bureau

Enclosure

115

Medical Center of Central Georgia

777 Hemlock Street P.O. Box 6000 Macon, Georgia 31208 (912) 744-1000

October 23, 1987

William L. Roper, M.D.
Administrator, HCFA
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Attached are the Medical Center of Central Georgia's Comments on the 1986 HCFA mortality data. Also attached is a listing of patients for whom we discovered significant data errors, including two patients who apparently did not die at all.

We persist in our belief that the release of HCFA mortality data to the general public is contrary to the public's best interest. The assumption that mortality rates are valid indicators of hospital quality of care is inaccurate. In fact, higher mortality rates may actually be associated with facilities which treat patients with unusually severe and complex illnesses and which must provide more advanced higher quality services.

We recognize that aggregate mortality data can be used to help identify areas where possible quality or practice problems do exist. Although it is our understanding that this will be communicated by you to the public at the time of the December data release, such a comment will not negate the harmful effect of this data release. It is naive to assume that the public will not be influenced to make decisions on this data as if it were a highly valid indicator of quality of care. Most unfortunately, many of these decisions will lead patients away from the hospitals which could most effectively and competently treat them.

We do believe, however, that the opportunity to comment on the data prior to the December release is positive. Our comments accompanying this mortality data will serve to provide the news media with information which should assist them in the preparation of stories which will be more informative than otherwise possible. Unfortunately, the positive impact of these comments can not neutralize the harmful impact on the public and hospitals which will necessarily result from this data release.

Sincerely,

Richard W. Turner
Director, Utilization Management

attachments (2)

...leading the way in health care

Medical Center of Central Georgia

777 Hemlock Street P.O. Box 6000 Macon, Georgia 31208 (912) 744-1000

October 23, 1987

COMMENTS ON THE 1986 HCFA MORTALITY DATA
Medical Center of Central Georgia, Macon, Georgia
Medicare Provider Number 110107

The data used by HCFA indicate that of a total of 481 Medicare patients admitted to the Medical Center of Central Georgia died within 30 days of admission. Of those, 401 reportedly died while still a patient of the hospital, while 80 died after discharge. Our records indicate that the actual number of Medicare patients who died in the hospital within 30 days of admission was 408. This discrepancy can be attributed to two types of errors in the Medicare data. First, 9 inpatient deaths were incorrectly assigned as outpatient deaths. Secondly, two patients identified as inpatient mortalities by HCFA actually did not die at all! (See attached names and HIC numbers of the patients involved in these corrections.) After correcting for the above misallocation of inpatient deaths to outpatient deaths, the number of patients listed by HCFA as outpatient deaths should be corrected to 71. It is impossible for the hospital to determine the percentage of these patients who supposedly died after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record. However a thorough review of the medical record of each patient who supposedly died after discharge has yielded (32%) for whom death could be considered likely at the time of discharge. The validity of the designation of the remaining patients as mortalities is, therefore, suspect.

In only one of the diagnostic categories, did the hospital's actual mortality rate fall outside of the range of the predicted mortality rate. And in that category, the number of patients by which this hospital fell out of the range was only one. This category was "Cerebrovascular Accidents, a category for which a high mortality rate should be expected considering the Medical Center of Central Georgia's role as referral facility for neurological patients throughout Central Georgia.

The omission of adequate severity of illness measures as well as recognition of tertiary referral hospitals in the HCFA model yields it inaccurate as a predictor of expected mortalities for a hospital such as the Medical Center of Central Georgia. This hospital is the primary referral hospital for almost all major specialties in the 50 county Central Georgia region. Referral services at MCCG include Cardiovascular, Neurology, Urology, Trauma, Neonatology, Gastroenterology, Oncology, and Infectious Disease. MCCG is the only hospital in the Central Georgia region at which Coronary Artery Bypass Grafting and Valve Replacement Procedures are performed. In truth, this hospital appearance in the upper portion of the predicted range for the category "All Causes" is most likely a result of an unusually high severity of patient illness resulting from the nigh quality and sophistication of MCCG as a tertiary referral hospital.

The problem of considering the severity of illness for the patients identified as Medicare deaths has been addressed in our review of these patient's medical records. Review of physician documentation was accomplished to identify cases for which death was considered an expected or likely outcome at the time of admission. In the category Cerebrovascular Accidents, the only category for which the number of mortalities at MCCG exceeded the range, our review indicated an extremely high severity of illness. Death could be considered the anticipated outcome for 46% of all patients in this group; and death was considered anticipated or likely for 69% ! Review of other categories generated similar results with some even more dramatic than those stated here. The presence of the remaining categories within the predicted range could very well be an indication of the delivery of high quality care in light of the unusually high severity of illness at the time of admission for many patients in these categories at MCCG.

Medical Center of Central Georgia

HCFA 1986 Mortality Data corrections

The following patients were erroneously listed as hospital deaths:



The following patients were listed as outpatient mortalities but were actually inpatient mortalities:



MCG

Medical College of Georgia
Augusta, Georgia 30912-2271

Hospital Administration
Hospital and Clinics

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

We are pleased to have an opportunity to review and respond to the mortality data prepared by the Health Care Financing Administration for release later this year. While we have significant concerns regarding the validity of the data when used to analyze mortality rates in specific hospitals, we do appreciate the steps that have been taken to improve the information and make it available for comment prior to public release.

Although this year's data appear extremely favorable for the Medical College of Georgia Hospital and Clinics (MCG), we have specific concerns regarding the general validity of the data and its intended use which include:

- The failure of the model to consider a wide range of factors with a significant impact on mortality, including: the patient's general health status, the stage of the patient's illness, the patient's psychological condition, and family support.

- Deaths being attributed to hospitals that are unrelated to the condition of the patient that was under treatment at the time of discharge.

- Deaths being attributed to hospitals that resulted from management of the patient at home or in a post-acute care facility.

- The basic fact that the model has not been validated.

We believe the intended preface "Statement of Interested Parties" will facilitate an understanding of the meaning and appropriate use of the data. However, we share the concerns regarding this statement that were previously forwarded to you by the Joint Commission for Accreditation of Healthcare Organizations and the American Hospital Association. We encourage you to consider incorporating the suggested modifications proposed by these organizations.

The data used by HCFA indicate that a total of 129 Medicare patients admitted in 1986 to MCG died within 30 days of admission. Of these, 95 were reported to have died while still a patient of the hospital, while 34 were reported to have died after discharge. MCG's records indicate that a total of 1950 Medicare patients were admitted during 1986. The HCFA statistics are based on 1495 Medicare cases reported. This discrepancy is presumably due to multiple admissions of individual beneficiaries to different hospitals.

Upon thorough examination of data provided by HCFA for review, the following specific discrepancies were noted:

- One reported death could not be verified as a former patient [redacted] Given the number of reported cases, this represents a 1% error in and of itself.

- One patient was identified with the incorrect HIC#. The report indicated patient [redacted] Following contact with the Social Security Administration, the patient was identified as [redacted]

- The principle diagnosis of five patients was reported incorrectly. Three cases resulted in a change in diagnostic category (a change in 2% of the reported deaths). Of these three cases, two were reclassified as Cancer and one as Severe Trauma--both high risk categories.

- Six patients reported to have been post-hospital deaths were shown to have expired in the hospital, representing a 5% reporting error.

In addition, MCG's review of the data indicated that:

- It was not possible to verify the reported deaths of 30 individuals discharged (23% of the reported cases), since information concerning death after discharge is not included in the patient's medical record.

- Upon reviewing the charts of the 30 patients reported to have expired after discharge, 20 of these deaths would have been anticipated (i.e., discharge summaries indicated terminal illness, referral to hospice care, "no code" orders, etc.).

- 43% of all cases reported by HCFA (and 27% of all reported deaths) fell into the "Other Diagnoses" category. MCG must question the potential impact on the validity of the data, particularly the overall mortality rates, given the excessively large proportion of "Other Diagnoses" cases represented.

Again, we appreciate the opportunity to review the data prior to its release. I trust these comments will lead to the resolution of our concerns.

Sincerely,

R. Edward Howell

R. Edward Howell
Executive Director

Medicare Provider #11-0034

memorial hospital

P. O. BOX 139 / 410 DARLING AVENUE / WAYCROSS, GEORGIA 31501 / (912) 283-3030

H. VIRGIL PARKER
EXECUTIVE DIRECTOR

October 20, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Hubert H. Humphrey Bldg., Room 314G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Provider No. 11-0003

Dear Dr. Roper:

Concerning the publishing of 1986 Medicare mortality rates for our hospital, we would like to point out that this data uses the UB-82 billing records as the main source for all information and that these codes may or may not be accurate. For example, there is no severity of illness measure in the model. It is statistical data and does not reflect quality of care. Yet, its release in its present form, is surely going to be interpreted as quality-of-care — reflections by the press and the public.

Another significant factor to note is that medical and surgical patients have not been identified. They are all grouped together and this makes comparisons inappropriate.

Releasing this statistical data without consideration of these and other internal factors, such as, older age groups, chronic illnesses, terminal illnesses, family and patient wishes concerning no codes, etc. causes the motives behind their release to become suspect — and that's motives of our own government and its agencies. The public will not understand these simple statistics. They will not know of the distortions or the shortcomings. And, we are appalled that an agency of our government would resort to such tactics.

Sincerely,

H. Virgil Parker

H. Virgil Parker
Executive Director
Memorial Hospital

:ch
cc

memorial hospital

P. O. BOX 139 / 410 DARLING AVENUE / WAYCROSS, GEORGIA 31501 / (912) 283-3030

Provider No. 110003

October 15, 1987

William Roper, M. D., Administrator
Health Care Financing Administration
Hubert H. Humphrey Bldg., Room 314G
200 Independence Avenue, S. W.
Washington, D. C. 20201

Dear Dr. Roper:

In regards to your letter of September 21, 1987 regarding the publishing of selected mortality information about all short-term acute care hospitals which treated Medicare patients in 1986, the Utilization Committee of Memorial Hospital feels compelled to respond.

Our hospital's mortality rate fell within accepted norms for all categories except severe acute heart disease. The range of predicted mortality rates for severe acute heart disease was reported to be 26% or 50% in your letter. Our mortality rate was 56%.

Since these mortality rates are being published for public scrutiny, and since the public may draw their own conclusions from these published statistics, we would like to point out some interesting facts. Among the 40 deaths classified as severe acute heart disease our Utilization Committee reviewed each chart and divided the patients into the following sub-groups:

a. Bradycardia with Cardiogenic Shock - 16 Patients:
Bradycardia with cardiogenic shock usually implies more severe, endstage heart disease with less chance of resuscitation. Also cardiac rupture and electro-mechanical disassociation are frequently found in this group of patients.

b. Coexistent Severe Disease such as Chronic Renal Failure, Chronic Lung Disease, Cerebrovascular Disease, Diabetes and Cancer - 16 Patients:
The significance of any of these severe diseases is obvious.

c. Cardiogenic Shock and Death Within 24 Hours - 2 Patients:
The short course ending in death is indicative of very severe myocardial injury.

d. Cardiomyopathy:
This is a disease of the heart muscle for which there is no known cure. This should probably be included under Chronic Heart Disease.

e. Rupture of Myocardium Proven by Autopsy - 2 Patients:
A ruptured myocardium following myocardial infarction is a feared catastrophic complication for which there is no effective treatment.

f. Patients with Dementia and Impaired State of Consciousness at Time of Admission - 2 Patients:
These patients were obviously chronically ill. Acute heart disease was another insult to their fragile state of health.

g. Acute Myocardial Infarction and Shock Following Surgery For Abdominal Aortic Aneurysm Rupture - 2 Patients:
The seriousness of these patients' illness and their increased risk of poor outcome is obvious.

h. Patient Transferred to Another Larger Facility with No Record of Death on Chart - 1 Patient:
This patient was included in our mortality rate because he died within 30 days of admission to our hospital.

Our Utilization Committee feels that until a reliable method for evaluating severity of illness is adopted, mortality statistics can present a very unfair perspective. All of the forty patients who were classified as dying from severe acute heart disease were actually chronically ill patients who could ill-afford any other insult to their health.

Respectfully submitted,

T. J. Ferrell, Jr., M. D., Chairman
Utilization Review Committee

TJF,jr/pb

MEMORIAL HOSPITAL AND MANOR

"Excellence in Service"

MEDICARE PROVIDER NUMBER - 110132

In verifying the Hospital Mortality Information mailed to Memorial Hospital on September 21, 1987, the following discrepancies were noted.

[redacted] The date of death was reported as 10/31/86. The actual date of death was 10/28/86. The patient died in the hospital, not 3 days after discharge.

[redacted]. The date of death was reported as 10/31/86. The actual date of death was 10/03/86. The patient died in the hospital, not 28 days after discharge.

[redacted]. The date of death was reported as 2/06/86. The actual date of death was 2/05/86. The patient died in the hospital, not 1 day after discharge.

[redacted] The date of death was reported as 12/16/86. The actual date of death was 12/19/86. The patient was admitted to the hospital on 12/06/86 and discharged on 12/09/86, was readmitted on 12/17/86 and expired in the hospital on 12/19/86. The diagnostic category that this patient was placed in was for the first admission and not the category that was for the last admission.

Memorial Hospital, Bainbridge, Georgia, is a JCAH accredited, 82 bed facility with 18 physicians on the medical staff. The facility serves a rural community of 25 thousand. Memorial Hospital staff and physicians are dedicated in providing quality care to all patients. Although our facility fell within predicted ranges of mortality rates, we assert that these statistics may be quite misleading. The statistics are merely numbers of deaths, arbitrarily placed in one of sixteen diagnostic categories. Fortunately, Memorial Hospital and other worthy institutions can not and will not view their patients as a number to be placed in a rigid category. The published mortality rates do not reflect the individual, nor a true picture of the quality of care provided by a facility. A compelling example would be that of a patient received at our facility suffering from terminal cancer. Though often treated by other excellent facilities with specialists, the patient may turn to his community hospital for support during the final stages. Memorial Hospital provides this necessary support and comfort measures. Quality care is indeed provided, though the statistics cannot reflect the death with dignity and support.

1500 E. Shotwell Street, Bainbridge, GA 31717 912/246-3500
Raymond Wright, Executive Director

Other areas to consider when viewing mortality rates of any institution, is that of, again, the individual. The average patient age in this study was 78 years. 96% of our mortality patients suffered from chronic degenerative conditions. Multiple medical problems such as diabetes, congestive heart failure, chronic obstructive pulmonary disease, and arteriosclerotic heart disease might be present. When present, these disease processes may certainly affect the patient outcome. However, upon demise the patient is assigned to one diagnostic category unreflective of any underlying medical condition. The diagnostic category that the patient was assigned to reflects the principal diagnosis which may not be the cause of death. The principal diagnosis is the one condition established after study to be chiefly responsible for admission of the patient to the hospital for care. The patient therefore, has become a number to be assigned for statistical data.

In summary, the patients presenting to Memorial Hospital are treated as individuals. Quality care is provided. Though our facility was within acceptable ranges for mortality rates, we maintain that these statistics are not a measure of quality.

Respectfully submitted,

Medical Staff and Administration

DATA VERIFICATION

According to data submitted by HCFA, 2981 Medicare beneficiaries were admitted to Memorial Medical Center, Inc. during 1986. Medicare admissions to Memorial during this period total 4970. This discrepancy is attributed to HCFA's counting only the last admission for patients with multiple admissions to one or more hospitals during the reporting year.

HCFA reported a total of 328 deaths in specified disease categories. Of these deaths, 267 expired during the hospital stay and 61 expired within 30 days subsequent to discharge. Memorial's records indicate 275 deaths were verified during hospitalization. Thirty-seven deaths were verified as occurring within 30 days post discharge. The status of the remaining 16 patients, discharged from the hospital alive, could not be confirmed.

Information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in their analysis.

INTERPRETIVE REMARKS

In one of the diagnostic categories, the hospital's mortality rate falls outside the range of the predicted mortality rate. Being lower than the predicated mortality range, there is no comment.

UNIQUE SERVICE RESULTING IN HIGHER THAN AVERAGE MORTALITY

No services resulted in higher than average mortality.

RESULTS OF PRELIMINARY MEDICARE RECORD REVIEW

Several admission dates were incorrect on HCFA mortality data, attributed to transferring the patient to Psychology and Rehabilitation Services and generating a split bill.

One case was a 1987 death and 1987 admission. Therefore, this case should not be counted in the cases listed as a pulmonary disease death.

P.O. Box 23089
Savannah, GA 31403-3089
(912) 356-8000

An affiliate of Provident Health Services, Inc.

INCONSISTENCIES IN HCFA DATA vs. MEMORIAL MEDICAL CENTER, INC., SAVANNAH, GEORGIA

1986 MEDICARE DEATHS

MEDICAL RECORD #	HIC NUMBER	ADMISSION DATE HCFA	ADMISSION DATE MMC	DISCHARGE DATE HCFA	DISCHARGE DATE MMC	DATE OF DEATH HCFA	DATE OF DEATH MMC	COMMENTS
[redacted]	[redacted]					12-31-86	12-12-86	
[redacted]	[redacted]					03-18-86	03-16-86	
[redacted]	[redacted]					03-11-86	03-10-86	
[redacted]	[redacted]					09-30-86	09-29-86	
[redacted]	[redacted]					02-26-86	02-27-86	
[redacted]	[redacted]					04-30-86	04-12-86	
[redacted]	[redacted]	12-06-86	01-02-87	12-12-86	01-03-87			here 12/6-12/12;but, died 1/2-1/3 Adm.
[redacted]	[redacted]	12-17-86	12-10-86					
[redacted]	[redacted]			06-25-86	06-26-86	06-25-86	06-26-86	
[redacted]	[redacted]					03-31-86	03-29-86	
[redacted]	[redacted]					08-02-86	08-10-86	
[redacted]	[redacted]					02-06-86	02-05-86	
[redacted]	[redacted]			06-28-86	06-29-86	06-28-86	06-29-86	
[redacted]	[redacted]	11-12-86	11-03-86					
[redacted]	[redacted]	06-27-86	06-23-86					
[redacted]	[redacted]	03-31-86	03-19-86					
[redacted]	[redacted]	11-20-86	11-07-86					
[redacted]	[redacted]	02-17-86	01-24-86					
[redacted]	[redacted]	06-09-86	06-08-86					

LEGEND: HEALTH CARE FINANCING ADMINISTRATION - HCFA
MEMORIAL MEDICAL CENTER, INC. - MMC

GA 113.1

INCONSISTENCIES IN HCFA DATA vs. MEMORIAL MEDICAL CENTER, INC., SAVANNAH, GEORGIA

1986 MEDICARE DEATHS

EDICAL RECORD #	HIC NUMBER	ADMISSION DATE HCFA	ADMISSION DATE MMC	DISCHARGE DATE HCFA	DISCHARGE DATE MMC	DATE OF DEATH HCFA	DATE OF DEATH MMC	COMMENTS
[redacted]	[redacted]	05-19-86	05-15-86					
[redacted]	[redacted]	03-25-86	02-16-86					
[redacted]	[redacted]	05-02-86	03-31-86					
[redacted]	[redacted]					02-23-86	02-21-86	
[redacted]	[redacted]					07-25-86	07-26-86	

LEGEND: HEALTH CARE FINANCING ADMINISTRATION - HCFA
MEMORIAL MEDICAL CENTER, INC. - MMC

GA 113.2

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*		
	In-hospital	Post-hospital	In-hospital	Post-hospital	
				Conf.	Non-conf
CA -- Cancer	32	10	33	6	(3)
CE -- Cerebrovascular Accidents	22	7	25	3	(1)
GC -- Gastrointestinal Catastrophes	8	1	8		(1)
GI -- Gastrointestinal Disease	8	3	8	1	(2)
GU -- Urologic Disease	8	2	8	2	
GY -- Gynecologic Disease	0	0	0	0	
HL -- Low Risk Heart Disease	12	1	12	1	
HM -- Severe Chronic Heart Disease	22	5	23	2	(2)
HS -- Severe Acute Heart Disease	35	1	35	1	
ME -- Metabolic/Electrolyte Disturbances	9	5	9	5	
OP -- Orthopedic Disorders	2	3	2	1	(2)
PN -- Pulmonary Disease	28	8	29	4	(3)
RN -- Renal Disease	2	0	2	0	
SE -- Sepsis	6	0	6	0	
TR -- Severe Trauma	10	0	10	0	
OP -- Ophthalmalogic Disease	0	0	0	0	
UN -- Other Diagnoses	63	15	65	11	
Total -- All Categories	267	61	275	37	16

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

GA 113.4

DEATHS POST DISCHARGE
Contact Physican's Offices

Patient Name	Diagnosis	Discharge Date	*Date of Death	Attending Physician
[redacted]	CA - Glioma	6/27/86	7/3/86	Geffen
[redacted]	CA - Kidney	9/25/86	10/14/86	Carlton
[redacted]	GI bleed - CA	3/4/86	3/19/86	Gaskin/Waller/Clinic
[redacted]	Stroke	11/03/86	11/30/86	WALLER
[redacted]	small bowel obs. vs. ileus	3/11/86	3/26/86	Flanders/Pike
[redacted]	GI/CA	7/18/86	8/1/86	Goldberg/Hilton Head
[redacted]	Heart	9/21/86	9/26/86	Donald Calebaugh/Beaufort
[redacted]	CHF	10/3/86	10/8/86	Westside Urban
[redacted]	Ortho	7/2/86	7/4/86	Mikell/Wessinger/Brown
[redacted]	CA prostate	4/11/86	4/20/86	Nichols
[redacted]	ESRD	8/15/86	8/15/86	Pope
[redacted]	Pulmonary	2/27/86	3/1/86	White Bluff Manor
[redacted]	COPD asthma	6/18/86	7/4/86	Waller/Clinic
[redacted]	Cholecystitis/ Bronchiectasis	12/24/86	1/13/86	DiBenedetto
[redacted]	CA - Lung	12/24/86	1/12/86	Morris/Rad. Rx
[redacted]		12/27/86	1/9/86	Clinic

*UNCONFIRMED DEATHS

NORTH FULTON REGIONAL HOSPITAL

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
200 Independence Ave. S.W.
Washington, D.C. 20201

Dear Mr. Roper:

Please include the attached comments with the 1986 mortality data release. Also attached is a corrected copy of the individual case listing provided to our hospital. The errors noted were dates of death. We have verified that our disposition codes were correct at the hospital level. Each corrected date was verified by review of the medical record. In each case, the date of death was shown to be after dismissal from the hospital; however, these patients expired during hospitalization.

Thank you for the opportunity to comment on the data.

Sincerely,

Brenda Bell

Brenda Bell, Director
Health Information Services

11585 Alpharetta Street, Roswell, Georgia 30076

A health care center of AMI

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

NORTH FULTON
REGIONAL HOSPITAL

October 23, 1987

Re: Mortality Rates, 1986 Provider #110198

Thank you for this opportunity to respond to the release of hospital mortality rates for 1986. This data has been carefully reviewed and we find the rates for our 175 bed acute care and rehabilitation facility are all within the predicted range with exception of one low rate (9% in the cancer diagnostic category with predicted range of 10% - 40%).

We acknowledge and appreciate HCFA's efforts in promoting high quality of care but recognize the ability of their statistical model to detect differences in quality has not been proven. Because of the value our Board, Medical Staff and Management places on quality of care provided by our hospital, we look forward to improved methods of measuring quality. Mortality rates alone do not indicate quality--judgements of quality can only be based on review of the actual medical record. Routine peer review of mortalities is a component of our hospital's quality assessment program along with multiple other measures to identify opportunities to improve care.

Review of HCFA's data and further review of the 76 mortalities (patients expiring in the hospital or within 30 days of discharge) has shown:

- -Errors in dates of death for six patients (disposition codes were verified as correct at the hospital level).
- -Average age of the patients was 79.5.
- -Of 76 deaths, 64 were included in the diagnostic categories utilized by HCFA for analysis. Of these 64, 54 were high risk cases (as defined by HCFA).
- -The renal disease category showed a rate of 67% (within the predicted range); however, there were only 3 patients with 2 deaths. Review of records has shown death was an expected outcome given the patients' medical conditions upon admission and the existence of chronic comorbid conditions.
- -With study of patients in the pulmonary disease category (24% rate, predicted 14% - 34%) it was found:
  - -14 of the 17 expired while hospitalized, and with 11 of these the patient and/or family requested no resuscitative measures.
  - -Aside from the prinicipal diagnosis of pulmonary disease, 14 (of 17) had at least two other significant comorbid conditions (conditions designated "significant" for use in HCFA's mortality analysis). 11 patients had at least one other significant comorbid condition.

In summary, our analysis has shown patients entering the hospital (many from nursing homes) in debilitated conditions for which death was one of several expected outcomes. Again readers are reminded the rates apply only to Medicare patients, rates alone are not predictors of quality, and our hospital maintains a program of on-going assessment of quality with continual efforts to improve the care provided.

11585 Alpharetta Street, Roswell, Georgia 30076

A health care center of AMI

Northeast Georgia
Medical Center, Inc.

743 Spring Street
Gainesville, Georgia 30501-3899
404/535-3553

October 19, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Northeast Georgia Medical Center, Inc. has received your letter dated September 21, 1987 and accompanying information regarding selected mortality information for 1986 to be published in December of this year. We are very appreciative to have received this data in advance of the release and to have the opportunity to share our comments with you.

Overall, we found the results of the data very favorable for our institution based upon your predicted ranges. One diagnostic category reflected that we were outside the range by only one percent. This category, Low Risk Heart Disease, has been reviewed by our medical and hospital staff and following are our comments:

Eighteen medical records of the nineteen reported deaths in 1986 categorized as Low Risk Heart Disease were reviewed for specific factors that may have impacted the patient's outcome. The average age of these patients was 74 years with nine of the nineteen patients being 80 years or older.

Specifically, the overall medical conditions of eight patients including the comorbidities and severity of illness reflect specific requests by the patients and/or family members for no further intervention resulting in "Do Not Resuscitate" orders. These elderly patients had additional medical problems such as histories of CVA's, chronic congestive heart failure, MI's, COPD, chronic essential hypertension, ruptured abdominal aneurysm, diabetes mellitus and others.

Seven of the nineteen patients arrived at Northeast Georgia Medical Center in an unstable and or unresponsive condition. Furthermore, of these seven patients, four were transferred to NGMC from another healthcare facility. Two patients requested to be discharged from the Medical Center and pursue recommended treatment plans at home.

VHA.
Affiliate of Voluntary Hospitals of America, Inc.

In summary, our review reflects that these were very sick patients, a fact which is not reflected in HCFA's Statistics. Although the principal diagnosis of these patients indicate Low Risk Heart Disease, other comorbidity data and the severity of the comorbities significantly impacts any patient's outcome regardless of DRG assignment. Additionally, the principal diagnosis may not reflect the actual cause of death. Therefore, our conclusions are that the patients did receive appropriate medical care during their hospitalization. We did not review the deaths of the other sixteen diagnostic categories, as the results of the HCFA data reflected we were within the ranges.

The Medical Center reviews one hundred percent of the mortalities that occur at the hospital. The review is done monthly and is coordinated with the appropriate Medical Staff Departments. This is one of several quality assurance programs in place for reviewing patient care services.

We welcome the opportunity to work with HCFA and support efforts to provide consumers information on the quality of patient care. Consequently, we strongly advocate valid and reliable data based on proven statistical methodologies including nationally acceptable severity of illness indicators that would provide needed insight into mortality and other patient care reviews.

Again, we appreciate the opportunity to respond to HCFA's data and we are looking forward to progress in the methodologies used to present such important information to the public in a meaningful fashion.

With warm regards,

John K. Pharr, Jr.,
Senior Vice President

JP/cjr

Paulding Memorial Medical Center

October 21, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

RE: HCFA Mortality Data Comments

Dear Dr. Roper:

The data submitted to our hospital by HCFA per your letter of September 21, 1987, indicated a total of fifty medicare patients admitted to Paulding Memorial Medical Center died within thirty days of admission. Of these, thirty-five died while still a patient in the hospital, while fifteen died after discharge. Our own records indicated nine-hundred and fifty-six medicare admissions occurred in 1986, while your records indicated there were five-hundred and twelve admissions. Presumably the discrepancy reflected multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of medicare patients treated at Paulding Memorial Medical Center is correct.

INTERPRETED REMARKS

The average age of the fifty medicare deaths recorded by HCFA was 79 years of age. Your data indicated that in all of the diagnostic categories, Paulding Memorial Medical Center actual mortality rate fell within the predicted mortality range.

UNIQUE SERVICES APPLICABLE TO PAULDING MEMORIAL MEDICAL CENTER

Our eighty-three bed community hospital has a one-hundred and thirty-six skilled nursing home attached. Our records indicate that the majority of cases where a nursing home patients becomes ill or about to expire, are transferred from the nursing home over to the hospital and admitted. Of the fifty deaths, eighteen of the patients were our nursing home patients, nine were eventually transferred back to the nursing home and died within thirty days in the nursing home.

600 W. Memorial Drive
Dallas, Georgia 30132
404/445-4411

I believe that having a skilled nursing home attached to a hospital will skew the mortality rates much higher than if a hospital does not have these facilities attached. There is an extreme shortage of nursing home beds in Paulding County, and we find we admit the more serious patients in these beds. These patients will be transferred from the nursing home bed to the hospital and will die. This causes a higher hospital mortality rate.

Of the fifty medicare patients that died, thirty-nine were expected, on admission, to die. This means, based on the admission diagnosis and the condition of the patients upon admission, thirty-nine of forty patients admitted were expected to die. Nine of the remaining ten patients were expected to die within thirty days, and these were the ones who went to the nursing home and then they died. There were ten of the patients in our hospital of the fifty that the family desired they not be CODED or have no respiratory or aggressive therapy pursued. Some refused feeding tubes, and various efforts not to prolong any suffering.

I believe the information we received from you under no circumstances could be used as a basis of judging the quality of care provided by this hospital. We expected forty-eight of the fifty that died to die, and there were no surprises. I believe if you want to consider some quality of care issues for hospitals, maybe you need to look at their quality assurance programs and not items such as mortality rates.

Sincerely,

Ray C. Brees
Administrator

kw

Pierce County Hospital – Nursing Home
CARTER AVENUE P. O. BOX 32
BLACKSHEAR, GEORGIA 31516

MEMBER: AMERICAN HOSPITAL ASSOCIATION
GEORGIA HOSPITAL ASSOCIATION
AMERICAN NURSING HOME ASSOCIATION
GEORGIA NURSING HOME ASSOCIATION

TELEPHONE
912-449-6631

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Hospital I.D. Number - 110055

Dear Dr. Roper:

The following information is submitted with reference to your letter of September 21, 1987 to all Hospital Administrators.

The information submitted by your agency, along with information abstracted from these patients records, were submitted to the physicians on our medical staff. This facility only had two (2) Diagnostic Categories that were considered by your Agency to be out of the predicted range of mortality rates.

After review of these charts by our Quality Assurance Committee, which includes our medical staff, we feel that there was no quality issue and the quality of care received by these patients was deemed beneficial by our reviewers.

There is an error on the information submitted by your office with reference to patient [redacted] You state that patient expired on 10-05-86 when the patient actually expired on 10-04-86 while in the hospital. Please correct your records accordingly.

Sincerely,

William V. Maxwell

William V. Maxwell,
Administrator

WVM/ss

PUTNAM GENERAL HOSPITAL
EATONTON, GEORGIA 31024
TELEPHONE (404) 485-2711

COMMENTS ON THE HCFA MORTALITY DATA

PUTNAM GENERAL HOSPITAL, EATONTON, GEORGIA 11-0144

Data Verification:

The data used by HCFA indicates that a total of 281 Medicare patients were admitted to Putnam General Hospital. Of these, 37 Medicare patients admitted to Putnam General Hospital died within 30 days of admission. Of these, 30 died while still a patient of the hospital, while 7 died after discharge. Our own records indicate that 404 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to the hospital. Of these 37 patients died. 32 Medicare patient's died while in the hospital and 5 died post discharge. Of these five that died post discharge, one was transferred to a Skilled Nursing Home and one to a Swing Bed at another medical facility. We have no way of knowing that the number of medicare patients you have stated were treated at our medical facility. A copy of analysis of reporting errors is attached and also the case listing is attached with correction of data from HCFA.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Remarks:

We are a rural hospital with 50 beds. In this community, there is a 92 bed skilled nursing home. Our patient's are also admitted from Skilled Nursing Homes and Swing Beds in Sparta, Georgia.

Of the thirty two Medicare patient's that deceased in our facility and the five that deceased post discharge, 13 were admitted from an SNF, 3 from a Swing Bed Unit in another medical facility, 1 from another hospital, and 20 from home.

Under the following categories:

CE: 3 total patients:
2 patients admitted in critical condition and family requested no codes on both.
1 patient dismissed home with stable vital signs, laboratory, and x-ray results.

CA: 4 total patients:
4 admitted with terminal carcinoma with two no codes; 2 resuscitated without response.

GC: 1 total patient:
1 patient admitted in critical condition with septic peritonitis and possible ruptured appendix; deceased in 1 hour 18 minutes after admission. Also had CHF, Electrolyte imbalance. Resuscitated without response.

GI: 2 total patients:
1 admitted from SNF with possible obstruction, dehydration, rule out CA, Ischemic Heart Disease; Appropriate medical care rendered; condition deteriorated.
1 admitted with cirrhosis liver, hepatic coma, anorexic, complete body jaundice, ethanol abuse; death imminent on admission.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Data Verification:

Continued: Page 2

[redacted] 1 total patient:
1 patient admitted from SNF post fall; underwent surgery. Patient had COPD, Pneumonia, CHF, and fatty embolus post operatively. Resuscitated without response.

[redacted] - Keypunch error by insurance clerk of 401.9 in lieu of 410.9 of admission date 9/17/86 deceased 1/19/86 with cardiac arrest and complete bundle branch block. Patient was ill times one week and unable to feed self. Resubmitted correct code to PRO 9/29/86; paid by correct code 11/13/86. This places this patient in HS category in lieu of HL category. Therfore actual mortality rate of HL is 0% and for HS 57%.

[redacted] 8 total patients: Above case is included in these numbers.
7 patients had acute myocardial infarctions with 1 patient transferred to our medical facility from another hospital . The patient had already had cardiac arrest prior to arrival to our facility with chest pain for 11 hours prior to admission. Imminent death. 2 patients were unresponsive upon admission with one being a no code per family request; 1 patient had severe COPD oxygen dependent at home, depressed, and lived alone; 1 patient had chest pain three hours prior to admission with PVC's and chest pain times two days. 1 patient was discharged home in a stable condition with admission diagnosis of cardiac arrhythmia's. Reason for death after dismissal unknown.

[redacted] 8 total patients:
Out of the eight patients admitted, seven were transferred to our medical facility from a skilled nursing facility. Of these seven, five were unresponsive and in critical condition upon admission to the E. R. with one being a no code per family request. 1 patient was transferred to an SBU post discharge on 5/6/87 for follow up care and deceased 5/18/86 with cause being unknown. 2 patient's were transferred to SNF for follow up care.

[redacted] admitted 8/2/86 transferred 8/19/86 was brought to the hospital DOA from SNF on 8/26/86 in lieu of HCFA date of death as 8/31/86.

[redacted] 6 total patients;
2 patients required surgery but the family refused surgery or further treatment.
[redacted] Admitted 12/29/86 deceased 12/30/86 error by HCFA stating date of death was 12/31/86. Patient had chest pain and diabetes.
[redacted] Patient admitted with abdominal pain and syncope with possible CA. Family requested no surgery and further treatment due to patient's age.
4 other patient's had multiple medical problems contributing to death.

[redacted] 2 total patinets:
Both patients had CHF; 1 had CHF, Renal Failure, and COPD. Both resuscitated without response.
[redacted] Admitted 1/4/86 deceased 1/6/86. HCFA stated date of death was 1/7/86. This patient died in the hospital on 1/6/86. Error by HCFA.

ME: 2 total patients;
1 treated and transferred to Swing Bed at another medical facility for follow up care; cause of death unknown.
1 patient admitted in poor condition with dehydration, renal failure, and cardiac arrhythmia's. Poor candidate for survival.

Respectfully submitted,

Vickie Lynn Holder, A.R.T.

Vickie Lynn Holder, A. R. T.
Director of Medical Records

ATTACHMENT 5

11-0144

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	4	0	4	0
CE -- Cerebrovascular Accidents	2	1	2	1
GC -- Gastrointestinal Catastrophes	1	0	1	0
GI -- Gastrointestinal Disease	2	0	2	0
GU -- Urologic Disease	0	0	0	0
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	1	0	1	0
HM -- Severe Chronic Heart Disease	1	1	2	0
HS -- Severe Acute Heart Disease	6	1	6	1
ME -- Metabolic/Electrolyte Disturbances	1	0	1	0
OP -- Orthopedic Disorders	0	0	0	0
PN -- Pulmonary Disease	5	3	5	3
RN -- Renal Disease	0	0	0	0
SE -- Sepsis	0	0	0	0
TR -- Severe Trauma	1	0	1	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	6	1	7	0
Total -- All Categories	30	7	32	5

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

PUTNAM GENERAL HOSPITAL
EATONTON, GEORGIA 31024
TELEPHONE (404) 485-2711

October 27, 1987

COMMENTS ON THE HCFA MORTALITY DATA
PUTNAM GENERAL HOSPITAL, EATONTON, GEORGIA 11-0144

Data Verification:

The data used by HCFA indicates that a total of 281 Medicare patients were admitted to Putnam General Hospital. Of these, 37 Medicare patients admitted to Putnam General Hospital died within 30 days of admission. Of these, 30 died while still a patient of the hospital, while 7 died after discharge. Our own records indicate that 404 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to the hospital. Of these 37 patients, 32 Medicare patient's died while in the hospital and 5 died post discharge. Of these five that died post discharge, one was transferred to a Skilled Nursing Home and one to a Swing Bed at another medical facility. We have no way of knowing that the number of medicare patients you have stated were treated at our medical facility. A copy of analysis of reporting errors is attached and also the case listing is attached with correction of data from HCFA.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Remarks:

We are a rural hospital with 50 beds. In this community, there is a 92 bed skilled nursing home. Our patient's are also admitted from Skilled Nursing Homes and Swing Beds in Sparta, Georgia. Medicare admissions comprised 32% of our total inpatient admission from October 1985 through September 1986. We are also surrounded by two large lakes, Lake Oconee and Lake Sinclair. Many retired persons are moving into our community due to these facilities. 12.9% of our couties population is 65 and older.

Of the thirty two Medicare patient's that deceased in our facility and the five that deceased post discharge, 13 were admitted from an SNF, 3 from a Swing Bed Unit in another medical facility, 1 from another hospital, and 20 from home.

Under the following categories:

CE: 3 total patients:
2 patients admitted in critical condition and family requested no codes on both.
1 patient dismissed home with stable vital signs, laboratory, and x-ray results.

CA: 4 total patients:
4 admitted with terminal carcinoma with two no codes; 2 resuscitated without response.

GC: 1 total patient:
1 patient admitted in critical condition with septic peritonitis and possible ruptured appendix; deceased in 1 hour 18 minutes after admission. Also had CHF, Electrolyte imbalance. Resuscitated without response.

GI: 2 total patients:
1 admitted from SNF with possible obstruction, dehydration, rule out CA, Ischemic Heart Disease; Appropriate medical care rendered; condition deteriorated.
1 admitted with cirrhosis liver, hepatic coma, anorexic, complete body jaundice, ethanol abuse; death imminent on admission.

R. T. Jones Memorial Hospital

MEDICARE PROVIDER # 11-0008

EXECUTIVE DIRECTOR
NEIL COPELAN

CHEROKEE COUNTY
HOSPITAL AUTHORITY

CARL BARRETT, CHAIRMAN
L. L. JONES, JR., VICE-CHAIRMAN
W. S. HATTENDORF, SECRETARY
E. O. MCFATHER, JR., TREASURER
WALTON C. DAVIS, JR.
ERNEST HALEY
LAMAR HARRIS
WILLIAM H. NICHOLS, JR., M.D.
HOLLAND WHEELER

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

The HCFA Mortality Study has used billing data to compute statistics about the cause of death. The principal diagnosis listed on the Medicare bill is not necessarily the cause of death. Only the patient's attending physician can determine the cause of death. This information can only be found in the medical record not on the Medicare bill.

When reviewing this study, please consider that 36% of the patient's in this study had "Do Not resuscitate" orders as per the wishes of the families and patients. 18% of these patients did not die in our facility.

One should not use these statistics to compare hospitals when there is question of validity. Our hospital as a part of the Quality Assurance Program performs their own Mortality Review. It is an ongoing review performed by the physicians themselves. Our physicians must insure that all physicians on staff are competent and accountable for their own acts.

Even though our hospital fell within the predicted ranges, we felt that the public should be made aware that certain aspects of this study are not valid.

Sincerely yours,

Neil Copelan

Neil Copelan
Executive Director

dl

HCA Redmond Park Hospital

October 22, 1987

Health Care Financing
Administration
Health Standards and Quality
Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Redmond Park Hospital—Comments on Medicare Mortality Data
Medicare ID#: 110168

TO WHOM IT MAY CONCERN:

The Health Care Financing Administration (HFCA) has determined an actual mortality rate of 9% for Medicare admissions at Redmond Park Hospital. This mortality rate is based on the number of patients whose last admission in 1986 was to Redmond Park Hospital, and who died within thirty (30) days of that admission. The HFCA data indicates that there were a total of 2,317 last admissions in 1986 and 215 of those patients died within thirty (30) days of that admission.

The data indicates those patients who died within thirty days of admission to the hospital, including those patients who died after being discharged from the hospital. Of the 215 deaths indicated by the data, 164 occurred while the patient was in the hospital and 51 or 24% occurred following the patient's discharge from the hospital. Redmond Park Hospital highlights these two figures simply to clarify the data that is presented.

The records at Redmond Park Hospital indicate that there were 185 Medicare deaths at the hospital during 1986. The difference between the figures of 164 and 185 can be accounted for by the patients who died in the hospital during an admission of thirty-one or more days.

Redmond Park Hospital is a regional referral center, serving a primary service area which includes six counties and approximately 253,000 people. The hospital had a Medicare utilization rate of approximately 58% during 1986. Redmond Park Hospital provides a number of sophisticated specialty services including neurosurgery, vascular surgery, open heart surgery, cardiology, oncology and pulmonology. The medical staff at Redmond Park receive a large

501 Redmond Road
Rome, Georgia 30161
Telephone (404) 291-0291
A subsidiary of HCA The Healthcare Company

number of patients on a referral basis from the primary care physicians in our service area. Patients are transferred to Redmond Park Hospital from several smaller area hospitals and from the many nursing homes in our service area. These patients can often have additional health problems that can contribute to the severity of their admitting diagnosis.

Redmond Park Hospital supports the opinion of the American Hospital Association (AHA) that the mortality data presented by HFCA are not, in themselves, measures of hospital performance. The data should not be used as the basis for judging the quality of care provided by different hospitals. The study data are based on the principal diagnosis identified by the patient's attending physician and the actual cause of death does not enter into the analysis. The statistical methods used to produce the "Range of Predicted Mortality Rates" presented in the data are extremely complex. These methods do not take into consideration all the patient characteristics that can affect the hospital's death rate. Severity of illness, the patient's health status, the patient's psychological condition and family support are factors that can also contribute to the probability of death and are difficult to measure and control in a study.

Redmond Park Hospital maintains an ongoing extensive quality assurance program. The quality assurance program monitors and evaluates the clinical aspects of all areas of care in the hospital. The quality assurance program involves the participation of hospital administration, clinical personnel and physicians. The HFCA mortality data can be used as another source of information in the hospital's quality assurance activities.

Sincerely,

Wm. Paul Rutledge
Administrator

cc: Mr. Jack O. Bovender
Vice President
Eastern Group Operations
Hospital Corporation of America
One Park Plaza
Nashville, TN 37202

RIDGECREST HOSPITAL

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Ridgecrest Hospital is a 45 Bed General Service Rural Facility located in Rabun County in the extreme north east corner of the state of Georgia.

The Medicare patient level for CY 1986 was 54.7% with the greater majority of these being from the low-middle income to low income financial status.

The mortality information indicates 28 medicare deaths related to the 30 day from last discharge date which is correct. Four of these deaths were after discharge with 2 of these being in nursing home facilities.

Of the 28 deaths 8 were from nursing home admissions all of which were expected deaths on admission with 7 being in the high risk category. Twenty one of the 28 total were high risk.

Statistical data indicates in the CA-Cancer Diagnostic Category 7 cases at 71% Acutal Mortality Rate to a Range of Predicated Mortality Rates of 5 to 65%. In this category a slightly higher predicated rate than actual. Each of these deaths were expected on admission, all were high risk admissions, with the exception of one there were co-morbid contributors and this one death was a "Swing Bed"admission from another hospital in terminal condition on arrival. The other four were admitted from home as noted in terminal condition.

The hospital stay and management of each of these patients was of a high degree with no discrepancies or deficiencies noted.

TURNER HOSPITAL CORPORATION

P.O. BOX 376 • CLAYTON • GEORGIA • 30525 • TELEPHONE (404) 782-4297

This Mortality Review and Mortality Rates should not be interpreted as a guage for level of care in any hospital. Every effort should be made on release of this information to assure this.

Sincerely,

Guy O. Fisher,
Co-Administrator

ROCKDALE HOSPITAL

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Please be informed that the 116 mortality cases listed for Rockdale Hospital have been verified to be correct.

As noted by HCFA, we feel that it is important for the public to understand that the mortality rate, on its own, is not a complete measure of quality of care, but a tool for health care providers to use in identifying areas needing review.

Sincerely,

Kim S. Hubbard

Kim S. Hubbard
Marketing/Community Relations
Director

KH/kss

1412 Milstead Avenue, N.E. Conyers, Georgia 30207-9990 (404) 922-8900

Provider #110187
Saint Joseph's Hospital of Dahlonega
1111 Mountain Drive, Dahlonega, Georgia 30533 (404) 864-6136

October 21, 1987

William L. Roper, M.D.
Administrator - HCFA
Washington, D.C. 20201

Dear Dr. Roper:

Although our hospital's percentage for all cases is within the predicted range, we appreciate the opportunity to submit this additional information concerning the mortality statistics your department plans to release in December. This information further supports the need for a significantly improved reporting and analysis system.

Our comments are being restricted to two categories as follows:

Gastrointestinal catastrophes
Severe Acute Heart Disease

Gastrointestinal Catastrophes:

Case 1 - 89 year old nursing home patient with Alzheimer's disease developed bowel obstruction. She was not a candidate for surgery with severe complicating medical problems. The decision was made with the family not to treat surgically because of these above complicating problems.

Case 2 - 95 year old admitted for IV therapy because of abdominal distention and total bowel arrest. By the second hospital day the patient began having bowel sounds, then on the third day vomited, aspirated and developed respiratory arrest. The family requested that she not be resuscitated.

Case 3 - 92 year old nursing home patient had a massive heart attack at the same time she underwent emergency surgery for bowel obstruction. However, she seemed to do well from that, then expired from cardiac arrest.

Case 4 - 82 year old female nursing home patient developed bowel obstruction. She underwent emergency surgery for this. During surgery much dead bowel was present. This was resected. However, the patient developed sepsis, kidney failure, respiratory failure. The family and the patient were Jehovah's Witnesses and refused blood transfusions which further complicated the patient's course.

Case 5 - 89 year old nursing home patient admitted with rectal bleeding from suspected diverticular disease. Had long history of kidney abnormality and heart disease. Stabilized in the hospital with clearing of rectal bleeding. The patient was discharged uneventfully from our facility to the nursing home and apparently expired within the next 30 days.

Severe Acute Heart Disease:

The second category where our facility exceeded the predicted was in this category. The average age in this category was 79. Median age 79. Review follows--

Case 1 - 87 year old with long history of diabetes. Came in with massive MI, also pneumonia, possible pulmonary embolus. The patient developed overwhelming congestive heart failure and died quickly thereafter.

Case 2 - 82 year old lady underwent full cardiac arrest at home, was transported by the family to a neighboring county physician office and was resuscitated there. The family requested no resuscitation after admission here. The patient had severe aspiration pneumonia and severe brain damage secondary to the cardiac arrest. The patient's cause of death was respiratory arrest.

Case 3 - 80 year old came in with myocardial infarction, had long standing high blood pressure, diabetes and heart disease. Went into cardiogenic shock at the time of admission and expired 15 minutes later.

Case 4 - 78 year old admitted to the emergency room at 5:10 p.m. in cardiopulmonary arrest. Successfully resuscitated. Transferred to the ICU still in shock, low blood pressure on monitor with heartbeat, some voluntary respirations - little else. The patient was pronounced dead in the ICU 1 hour and 13 minutes after admission.

Case 5 - 74 year old with long standing history of high blood pressure and diabetes. Came in with myocardial infarction, developed congestive heart failure and severe pulmonary edema and died secondary to that.

Case 6 - 78 year old with long history of heart disease - this patient had already had two previous MI's. Had full cardiac arrest at home and was resuscitated by the emergency medical service and the emergency room. Needed Intensive Care but had falling out of blood pressure and again had cardiac arrest the day after admission. The family requested no further resuscitation on the patient.

Case 7 - 85 year old nursing home patient. The patient and family had previously requested no resuscitation because of age and poor medical condition. The patient had a massive CVA and MI - also developed pneumonia and congestive heart failure. Kidney failure also developed at the end of hospitalization and the patient died with complexity of severe multiple medical problems.

Case 8 - 65 year old admitted in cardiorespiratory arrest. Resuscitated successfully in the ER. Placed on ventilator which was requested to not be continued by the family. The patient was able to breath spontaneously with O2, Isorpril and Lidocaine also given. Cardiac activity, however, ceased and no further attempt at resuscitation was made.

In some instances contributing factors could have been the fact that without a local hospice, patients in terminal stage of disease often choose to die in our facility rather than at home. As with many facilities our size we do not have a full-time Cardiologist on our staff. However, after case review the Chairman of Quality Assurance felt that even with a Cardiologist in attendance, in these cases, the outcome would have been the same.

Thank you.

Sincerely,

Tommy G. Reddin
Vice-President/
Chief Operating Officer

/pdl

SOUTH FULTON HOSPITAL

1170 Cleveland Ave., East Point, GA 30344
(404) 669-4000

October 20, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

MEDICARE PROVIDER # 11006

Dear Doctor Roper:

This is in response to your letter dated 9/21/87, regarding plans to publish certain selected mortality information.

We have reviewed the mortality data and offer the following comments:

(1) All of the Admissions have been confirmed.
(2) Discrepancies were found in five cases between the date of death according to our records and the HCFA data.

HIC #	PATIENT	EXPIRED-So.Fulton	HCFA
[redacted]		2-26-86	3-5-86
		12-25-86	12-31-86
		12-18-86	12-17-86
		11-17-86	11-19-86
		6-19-86	6-26-86

(3) South Fulton was in the range of predicted mortality rates in all 16 categories.

We appreciate the opportunity to review the information prior to publication and look forward to a cooperative effort in the development of a more comprehensive methodology to accurately evaluate and identify quality patient care.

Sincerely,

Clyde E. Maxwell, Jr., FACHE
President and Chief Executive Officer

CEMjr/lm

cc: Carol M. McCarthy, Ph.D., President, AHA
Joseph Parker, President, GHA
Charles P. McJunkin, President, VHA of Georgia

LEADING WITH CARE

St. Francis Hospital

October 28, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I am writing to provide additional information regarding the mortality data recently forwarded to us relative to our Medicare patients treated in 1986.

The Health Care Financing Administration (H.C.F.A.) reported two hundred thirty-two (232) patients in the category of Low Risk Heart Disease, the only category out of seventeen (17) in which your data indicated our results were above the range of predicted mortality rates.

Our records indicate we treated three hundred sixty-nine (369) patients in the above referenced category with a resulting mortality rate of 6%, not 9% as reported. As reported in your data, 6% is within the range of predicted mortality rates. This being the case, the mortality rates at St. Francis Hospital for all seventeen (17) categories are within the range of predicted mortality rates as established by H.C.F.A.

The medical records of all twenty (20) patients in the Low Risk Heart Disease category who died were reviewed in depth and the following was determined:

(1) Four patients had Open Heart Surgery.

(2) Five patients required the use of a Heart-Lung Machine.

(3) Two patients had Cardiac Catherizations.

(4) Two patients required Pacemaker insertions.

Also, other multisystem diseases and conditions were present to include severe Malnutrition, Dehydration, Occlusive Arterial Disease requiring amputations, an Aortic Aneurysm, Bacterial Endocarditis, Pnenmonia, Lung Cancer and severe Chronic Obstructive Lung Disease.

To further indicate the severity of illness, four (4) patients required transfer to our facility, six (6) required Cardiopulmonary Resucitation and fourteen (14) of the twenty (20) who were in a critical state when admitted were admitted through our Emergency Room.

2122 Columbus Manchester Expressway • P. O. Box 7000 • Columbus, Georgia 31995-5999 • Telephone (404) 322-8281

Our conclusion is that these patients should not have been considered as "Low Risk" but indeed were seriously ill and had an average age seventy-five (75). In addition, eight (8) of the patients and/or families in conjunction with the attending physician(s) had concluded that no heroic measures should be taken due to the serious conditions manifested.

That the quality of care provided to patients at St. Francis Hospital is uppermost in the minds of our medical st[illegible] and hospital staff is demonstrated by the fact that all of these patients' records were reviewed at the conclusion of their course of treatment and considering the serious patient conditions being treated, were found to have been managed appropriately.

We appreciate the opportunity to comment on the data provided by H.C.F.A. and agree with feelings expressed by you in your letter of September 21, 1987, to the effect that the statistics are not a complete measure of quality of care and that judgments about quality should be reserved until additional statistical measures are developed which will deal with such issues as severity of illness.

Sincerely,

John C. Anderson
Associate Administrator

JCA/kf

St. Joseph Hospital
CENTER FOR LIFE

October 26, 1987

William L. Roper, M.D.
Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

St. Joseph Hospital has completed a review of the mortality data developed by the Healthcare Financing Administration. The attached data appears to be correct with a few exceptions such as, incorrect discharge dates. These corrections are indicated on the attached pages. Because this information is intended for public release, there are several brief issues which I feel deserve comment. First, we have some concern regarding the particular variables and other limitations of the model used to develop the HCFA Mortality Rates. It should be understood that the model variables are limited and only account for Medicare patients. Second, a thorough review of the patient charts indicates that each patient had numerous comorbid conditions, or illnesses, which may have contributed to a death. This is not adequately taken into account in the mortality data model. Furthermore, St. Joseph Hospital provides services to certain high risk patient populations. These services include, but are not limited to, a cancer service and the only Hospice service for the terminally ill provided in our region. Third, the Augusta area has for some time experienced a problem with the availability of nursing home beds. This often forces patients who no longer require acute care but who are terminally ill, to remain in hospital beds, versus returning to a nursing home where appropriate care can be delivered. Those patients who are terminally ill often die in the hospital without ever returning to a nursing home.

Although we do have concern over the validity and perceived uses of the mortality data, as calculated by the Healthcare Financing Administration, it should be noted that St. Joseph Hospital has active utilization review and quality assurance programs through which this data has and will continue to be reviewed. All hospital deaths are screened through these programs using specific criteria. Based on these criteria, cases are reviewed by the members of the Medical Staff to determine appropriateness of care. These programs involve the Medical Staff, Hospital Management, and the Board of Directors of St. Joseph Hospital.

2260 Wrightsboro Road
Augusta, Georgia 30910-3199
(404) 737-7400

Sponsored by
Sisters of
St. Joseph of Carondelet

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

In summary, we will like to reiterate several points. First, St. Joseph Hospital is concerned with the quality of care delivered to its patients. Second, all of the patients used in the mortality data calculations had illnesses or underlying conditions which may have contributed to their death and this is not adequately considered in the HCFA model. Third, the data used to calculate mortality rates for hospitals only take into account Medicare patients. It is for these reasons that we feel the mortality information developed by HCFA is a poor indicator of quality which means little when taken out of the context of a complete quality assurance program in a specific hospital.

Thank you for the opportunity to comment.

Sincerely,

Vincent C. Caponi

Vincent C. Caponi
Administrator

St. Joseph's Hospital, Inc.
11705 MERCY BOULEVARD
POST OFFICE BOX 60129
SAVANNAH, GEORGIA 31420-0129

October 21, 1987

Phone: 912/925-4100

Call Correspondent direct at:

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the mortality information which the Health Care Financing Administration intends to publish in December.

You and other speakers from HCFA have called these data "limited," "rough," "a crude measure," and "not a complete measure of quality of care." I concur.

The data can be valuable insofar as they raise questions. Unfortunately, they are likely to be widely seen as providing answers.

For these reasons, even a hospital like our own which has an "excellent record" according to these statistics, should go on record with some relevant commentary.

It stands to reason that hospitals which because of their level of expertise attract a number of sicker patients, will have a higher mortality rate. The other side of that fact is that those same hospitals because of the same expertise offer a greater survival chance to those same patients.

The Diagnosis Related Group system of payment is intended to focus, not on the patient's most serious health problem, but on the illness which necessitated this hospitalization for the patient. Thus a patient may suffer from a terminal disease, but require hospital care only for a lesser one. This has a certain validity inasmuch as the DRG system is merely a payment system and not a measure of severity of illness - so long as everyone understands that limitation!

I would like to restrict my comments on our specific statistics to those patients (just under 10%) whom the HCFA listing describes as being at "low risk" for death according to the DRG into which they were classified.

William L. Roper, M.D. October 21, 1987

This is a total of nineteen patients whose average age was 76. Twenty-five percent of these patients had known cancer; others suffered from similarly grave diseases such as gangrene, liver cirrhosis, and congestive heart failure. Without exception, these nineteen patients had multiple medical problems. Only within the DRG system would they be called "low risk."

None of us with any altruism about our mission to care for the sick and injured can do anything but applaud efforts to measure the quality of that care. In our hospital we are constantly measuring quality with the different instruments at our disposal. These mortality statistics, despite their dramatic limitations, give us every reason to feel that we are fulfilling that mission.

Sincerely,

Sister Mary Faith

Sister Mary Faith, R.S.M.
President

SMF:dw

SAINT
MARY'S
HOSPITAL

1230 BAXTER STREET/ATHENS, GEORGIA 30613 / 404-548-7581

Provider No. 110006

Comments on the Selected
Mortality Information Released
to St. Mary's Hospital
by the
Health Care Financing Administration (HCFA)
Dated September 21, 1987

St. Mary's Hospital is a 196 bed, acute care, general hospital located in Athens, Georgia. The hospital has been operated since 1938 under the auspices of the Missionary Sisters of the Most Sacred Heart of Jesus, a missionary order of the Roman Catholic Church. Space limitations imposed upon this response prohibit a complete picture of the hospital and its patients which would be meaningful to public scrutiny of the data to be released. The medical staff of the hospital, comprised of 120 physicians and dentists, most of whom admit and treat Medicare patients, consists mainly of specialists and subspecialists representing the majority of the medical disciplines. The hospital has an active peer review program complying with the quality assurance standards of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission on Accreditation of Hospitals). The hospital is proud of the fact that it has been accredited continuously since 1954 when the Joint Commission was founded.

Admissions to St. Mary's Hospital are predominantly from a ten-county area in Northeast Georgia. In the past twelve months the hospital provided in excess of fifty-five thousand days of care to adult, pediatric, and newborn patients. Forty-four percent of the total days of care were rendered to Medicare patients. Many of these patients were transfers from nursing homes and other hospitals outside Athens but within our service area.

Without comment on the validity of HCFA's statistical methodology (there is ample comment on this by the Joint Commission and the American Hospital Association which is already a matter of record), we note that our mortality data are all within the ranges of predicted mortality rates. Even so, we wish to point out that in many instances the diagnostic categories used by HCFA may not reflect the actual causes of death. Understanding St. Mary's and the mortality data attributed to it

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

also requires a review of the nature and extent of the illnesses and injuries of its Medicare patients. Generally, the medical condition of these patients upon admission to the hospital included multiple diagnoses. When viewing the data on these patients, it is not valid to rely primarily upon billing information ("principal diagnosis") since other serious complications must often be taken into account. We also note parenthetically that the average age of the Medicare patients in the data released for St. Mary's was 78, and 28% of the total were over age 85, an age category where death is more probable, particularly when combined with serious illness or injury.

The data released by HCFA could have some limited value to St. Mary's Hospital in its quality assurance review efforts. However, St. Mary's believes that measuring quality, particularly in regard to human mortality is a far more complex task. Assessment of quality has been and will continue to be a priority activity at St. Mary's. Although we evaluate statistics and document trends, these cannot replace individual scrutiny of each death occurring in the hospital. St. Mary's will continue to thoroughly review with its medical staff all deaths occurring in the hospital, both Medicare and non-Medicare, to determine the cause of death, the presence of complications, the diagnosis, the treatment given, and other relevant factors. It is only through intensive review of each death occurring in the hospital that substantive information can be produced about the care and treatment rendered in the hospital and whether or not it was appropriate for the condition of the patient. St. Mary's quality assurance efforts do not stop at reviewing deaths. The program systematically reviews and evaluates information regarding all of the activities in patient treatment areas guided by the standards for quality assurance promulgated by the Joint Commission.

HCFA's compilation of mortality statistics for Medicare patients may be a start in the effort to offer the public information about quality of care, but the limitations must be understood and made public. For example, St. Mary's believes that it is important to recognize that each hospital has its own unique patient mix involving many more variables than those selected by HCFA, not the least of which is the severity of the illnesses and injuries treated. We would urge that it be made clear to the public that generalizations about quality of care at any given time or place cannot and should not be drawn from the current HCFA mortality data.

* * *

10/26/87

SAINT
MARY'S
HOSPITAL

1230 BAXTER STREET/ATHENS, GEORGIA 30613 / 404-548-7581

EXPLANATORY NOTE
ON THE CORRECTIONS TO
MORTALITY INFORMATION RELEASED
TO SAINT MARY´S HOSPITAL
BY THE
HEALTH CARE FINANCING ADMINISTRATION (HCFA)
DATED SEPTEMBER 21, 1987

CONFIDENTIAL

Hospital ID Number - 110006

Corrections to HCFA data as listed below:

1. Five (5) corrections made under principal diagnosis.
2. Eleven (11) corrections made under date of death.
3. Ten (10) additional deaths listed by social security number and name.

SUMTER REGIONAL HOSPITAL
"New Horizons In Health Care"

100 Wheatley Drive
Americus, GA 31709
(912) 924-6011

Office of the
Administrator

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: Mortality Statistics for Provider #11-0044

Dear Dr. Roper:

After reviewing the Mortality Listing, we find the following discrepancies which should be corrected prior to publication.

1. [redacted]
   Hospital Admission 02/12/86 Discharged 02/28/86
   Listed date of death 02/29/86
   Actual date of death 02/28/86 in the hospital.

2. [redacted]
   Hospital Admission 08/05/86 Discharged 08/13/86
   Listed date of death 08/12/86
   Actual date of death 08/13/86 in the hospital.

3. [redacted]
   Hospital Admission 07/15/86 Discharged 07/22/86
   Listed date of death 07/23/86
   Actual date of death 07/22/86 in the hospital.

4. [redacted]
   Was admitted 01/20/87 and expired 01/20/87
   This patient should not be on 1986 list.

5. [redacted]
   Admitted 08/01/86 Discharged 08/01/86 to Columbus Hospital. Expired 08/09/86 in Columbus Hospital.
   Should not be on list for Sumter Regional Hospital.

6. [redacted]
   Listed with wrong HIC number.

After revision of the listing to reflect the above needed corrections, the listing for Sumter Regional Hospital reflects that it is important to note that twelve out of fifteen patients were transferred to nursing home care, some at a stabled level, but most at a custodial level with poor prognosis. All patients were stable at the time of discharge. One patient refused further treatment and was returned to a nursing home for supportive care.

Ten out of fifteen patients were admitted from nursing homes. Those patients had multiple medical problems, were debilitated from CVA, CMF, COPD, status post amputation of lower extremities, cancer, etc. They were admitted with exacerbation of one, or all of these chronic conditions.

Sumter Regional Hospital agrees with the VHA that thirty days from the patient's admission is too long to associate cause and effects of the hospital care and the patient's death. A great deal can happen in thirty days, especially for those patients categorized as High Risk. Questions arise concerning post-hospital resources, was the patient/family compliant or non-compliant, what was the patient's status at the time of discharge? If the patient was stable at the time of discharge, would death occurring up to thirty days after admission necessarily be attributable to the care given by the hospital? There are no indications of the severity of illness at the time of admission contained in the statistics. The statistics imply a lack of quality on appropriateness in the care given by the hospitals. In order to properly assess this statistical information, there are many things one must know such as, whether the patients were terminal at the time of admission, and/or whether the patients were under a "no-code" status.

If a patient is in the High Risk category and is admitted to a hospital and subsequently dies, is this necessarily an indicator of hospital performance? Patient outcome may have been the same regardless of <u>any</u> interventions.

Regardless of what verbal qualifiers HCFA may use to accompany the statistical information in its presentation, what sticks in the consumer's mind is that ABC hospital has more deaths than XYZ hospital down the street. To allow the dissemination of such truly incomplete information to the public in today's environment is unjustified.

Sincerely,

James R. Griffith

Tanner Medical Center/Villa Rica
P.O. Box 638
601 Dallas Road
Villa Rica, Georgia 30180
(404) 459-3681

Tanner Medical Center Villa Rica

Professionals in the profession of caring.

October 19, 1987

Data Verification:

The data used by HCFA indicate that a total of 29 Medicare patients admitted to Tanner Medical Center/Villa Rica died within 30 days of admission. Of these, 20 died while still a patient of the hospital, while 9 died after discharge. Our own records indicate that 508 Medicare admissions occurred in 1986. Presumably any discrepancy in percentage of deaths per category could exist because HCFA data does not reflect mutiple admissions of an individual beneficiary to the hospital. Our yearly statistics verify the number of Medicare patients treated at Tanner Medical Center/Villa Rica is 508. Our own records also indicate that of the 29 Medicare patients who died within 30 days of admission, 9 were still alive at the time of discharge.

In one of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predictated mortality rate. Several factors account for this difference.

HCFA statistics do not reflect multiple admissions to the hospital, therefore, percentage of deaths would be lower when taking this fact into account. Of the 7 deaths in the "Ca" category, 5 were inpatient deaths and were considered terminal on admission. Of the 2 patients who died following discharge, one was considered terminal and the other was a death by self-inflicted injury.

Of the 9 patients who died following discharge, 4 were brought into this institution as DOA patients; 3 died in a neighboring county and were taken to that county hospital as DOA patients; and 2 died in a neighboring county and were pronounced dead at their homes by the county Medical Examiner.

Ann Olson

Ann Olson, A.R.T.
Medical Records Department

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	5	2	5	2
CE -- Cerebrovascular Accidents	1	-	1	-
GC -- Gastrointestinal Catastrophes	1	-	1	-
GI -- Gastrointestinal Disease	2	-	2	-
GU -- Urologic Disease	-	-	-	-
GY -- Gynecologic Disease	-	-	-	-
HL -- Low Risk Heart Disease	-	1	-	1
HM -- Severe Chronic Heart Disease	1	1	1	1
HS -- Severe Acute Heart Disease	-	-	-	-
ME -- Metabolic/Electrolyte Disturbances	-	2	-	2
OP -- Orthopedic Disorders	-	-	-	-
PN -- Pulmonary Disease	5	1	5	1
RN -- Renal Disease	-	-	-	-
SE -- Sepsis	3	1	3	1
TR -- Severe Trauma	-	-	-	-
OP -- Ophthalmalogic Disease	-	-	-	-
UN -- Other Diagnoses	2	1	2	1
Total -- All Categories	20	9	20	9

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

The Medical Center, Inc.
Columbus, Georgia

LARRY SANDERS, FACHE
PRESIDENT AND
CHIEF EXECUTIVE OFFICER

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Please find attached our hospital's response to the 1986 HCFA Mortality Data.

Sincerely,

Larry Sanders

Larry Sanders, FACHE
President and Chief
Executive Officer

/rdn

Attachment

710 CENTER STREET ☐ POST OFFICE BOX 951 ☐ COLUMBUS, GEORGIA 31994-2299 ☐ TELEPHONE 404/571-1000

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

The Medical Center, Inc.
Columbus, Georgia

Medical Provider
No. 110064

RESPONSE TO 1986 HCFA MORTALITY DATA
The Medical Center, Inc.
Columbus, Georgia

These data include a statistical analysis of 1,762 (62%) of the total 2,856 Medicare patients admitted to The Medical Center in 1986. Of these 1,762 cases, 201 (11%) died while in the hospital and 48 (3%) died after discharge, within 30 days of admission. This information has been taken by the Health Care Financing Administration from Medicare billing data and includes Medicare patients only.

We endorse the intent to develop meaningful indicators of healthcare quality, but emphasize that mortality data alone does not measure healthcare quality; rather, mortality data can be a screening tool to identify areas of care that may need additional physician review. We also point out that two important patient characteristics are omitted from these data: the severity of the patient's illness and the cause of death. Thus, a hospital that treats many severely ill patients may have a mortality rate that is higher than predicted, yet not unusual considering these patients' severity of illness. These data may also include deaths unrelated to the hospital admission; for example, deaths resulting from accidental injury that occurred after leaving the hospital. It is recommended that interested consumers discuss the applicability of this information with their physicians, but should not draw conclusions from these data concerning the quality of care provided at any particular hospital.

THE MEDICAL CENTER'S QUALITY ASSURANCE ACTIVITIES:

The Medical Center has a demonstrated commitment to quality health care. Evaluations of hospital and patient care quality are conducted daily through an ongoing program of quality assurance activities designed to evaluate and assess the care delivered in the hospital and to ensure that problems are identified and corrected. These established activities include daily reviews of all surgical cases and adverse drug reactions, as well as reviews of medical records, to ensure that appropriate care was given. Quality review activities are conducted continuously to monitor and evaluate the care provided in each patient care department of the hospital. In addition, every death reported at The Medical Center is reviewed by physicians within each clinical specialty to assess the quality of care provided to the patient. The findings of these activities are reported bimonthly to the hospital's Quality Assurance Committee, made up of representatives from management and the medical staff. Findings are routinely reviewed by the hospital Board of Directors.

Another measurement of hospital quality is accreditation by the Joint Commission on Accreditation of Healthcare Organizations (formerly the Joint Commission on Accreditation of Hospitals). In 1986, the Joint Commission awarded maximum 3-year accreditation to The Medical Center through a voluntary, on-site evaluation using nationally recognized standards to evaluate quality patient care. The Joint Commission is governed by a board of commissioners whose members are appointed by the American College of Surgeons, American College of Physicians, Amercian Dental Association, American Hospital Association and the American Medical Association. A public member is appointed by the Board of Commissioners to represent consumer concerns.

COMMENTS ON CATEGORY PN - PULMONARY DISEASE:

This category includes chronic lung diseases, pneumonia and other lung conditions that contribute to an overall debilitating health status. Thirty-nine deaths were reported in this category, for an overall mortality rate of 30%. All patients in this category had secondary diagnoses contributing to poor health. In many cases, pneumonia was the final event in patients with multiple organ disease and/or failure.

All cases in the category were reviewed in an effort to evaluate the care given. Physician review was conducted in some cases in order to determine an anticipated result from treatment. Upon review, all cases were found to be chronically ill, and death was not an unexpected outcome in any case. Twenty of the 39 cases in this category were terminally ill patients who, by personal or family request, had specified that aggressive resuscitative measures to prolong life not be entered into. Six of these cases had terminal cancer and five suffered from end stage renal disease. One suffered from both cancer and end stage renal disease.

Turner County Hospital

615 E. Washington

Ashburn, Georgia 31714

October 19, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

We are in receipt of the analysis regarding mortality information.

According to your analysis, Turner County Hospital was within range of all categories except (RN) Renal Disease.

In a review of these admissions, all three (3) patients had multiple admissions to the hospital over a long period of time with terminal renal failure.

It is requested these facts be considered before publishing.

Thank you,

Vernon L. Griffin
Administrator

VLG:tn

UNION GENERAL HOSPITAL
AND
UNION COUNTY NURSING HOME

LEON DAVENPORT
ADMINISTRATOR

AREA CODE 404
745-2111

20 October 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Medicare Provider # 11-0051

Dear Sir/Madam:

In response to letter dated 21 September 1987 re Mortality information, the following comments are provided on behalf of Union General Hospital.

First of all, it was requested that we advise of any inaccuracies in the data received. In this connection, please be informed that:

+ [redacted], Adm 7-10-86 was transferred 7-12-86 to District Memorial Hospital, Andrews, NC; and, it is felt this death should be chargeable to District Memorial Hospital.

+ [redacted], Adm 12-7-86 was transferred to Georgia Baptist Hospital, Atlanta, GA on 12-9-86; and it is felt this death should be chargeable to Georgia Baptist Hospital.

+ [redacted], Adm 4-8-86. This patient died 4-13-86 instead of 4-14-86.

We do not concur that this facility's Actual Mortality Rate for CANCER should be considered above average; however the following comments are provided regarding these deaths:

ROUTE 8, BOX 8403 (HOSPITAL)
ROUTE 7, BOX 7650 (NURSING HOME)
BLAIRSVILLE, GEORGIA 30512

1. This 45-bed rural hospital has an extremely limited number of newly diagnosed Cancer patients in that we do not provide Cancer surgery or radiation, nor do we initiate chemotherapy. Admission to this hospital is either due to metastasis (spreading) or complications of the malignancy while the patient is in a terminal stage.

2. Of the nine Cancer deaths, five had Do Not Resuscitate orders. All of these patients had Cancer diagnosed at another facility, and were admitted to this hospital due to spreading of the disease.

3. Ages of these patients were 65, 68, 69, 70, 74, 75, 80, 86, and 89, an average of 75.1.

4. An additional comment, though not germane to the issue, is that our charges for treating these nine patients was $29,574.40, while DRG payment was $14,351.00 -- a shortfall of $15,223.40.

The opportunity to comment is very much appreciated, and if further information can be provided please feel free to advise.

Sincerely,

Leon Davenport
Administrator

LD:kh



UPSON COUNTY HOSPITAL
801 WEST GORDON STREET ◆ THOMASTON, GEORGIA 30286
OFFICE OF ADMINISTRATOR

October 21, 1987

Dr. William L. Roper
Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Re: Mortality Statistics
Provider #110002

Dear Dr. Roper:

The mortality information sent with your letter dated September 21st has been reviewed by our administrative personnel, medical staff and Hospital Authority. We would like to submit the following information for publication along with your data.

The data gathered by HCFA indicates that a total of 181 Medicare patients admitted to our facility died within thirty days of admission. Of these, 136 died while a patient of the hospital and 45 within thirty days of discharge from the hosptial. Our Medicare data varies from your data in that we show 1,487 admissions, not 1,025 as you indicate and our records further indicate that no deaths were counted if the patient stayed longer than thirty days.

In the 16 diagnostic categories studied, the hospital's mortality rate falls outside the range of predicted mortality rate in four of the categories. After studying the medical record of each patient falling into the range outside the predicted (103 of 181) we have a lower mortality rate than indicated by your study. Several factors may account for this difference. Intensive review was done to account for the variance found.

1. The diagnostic categories selected for study are based on the principal diagnosis as listed on the physician's attestation. This was not always the cause of death therefore yielding invalid statistics. Forty-four records indicated the cause of death was different from the principal reason for the admission. Two of these are from autoposy reports.

2. On admission there were pre-existing health status factors in 20 of the patients that would cause the patient to be placed in the expected death category where family members were aware and understood the gravity of the patient's condition and requested no cardipulmonary resusitation at the time of admission.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

3. There were 40 admissions where comorbidities, complications and test results indicated eminent death and the family requested no heroic measures (CPR or life support) be used to extend life. This request was made from 2 to 15 days into the hospitalization.

4. Heroic measures (CPR and life support) were taken to save the lives of 23 patients without success.

5. Analysis of the 20 post-hospital deaths that are counted in our mortality rate reveals that six were discharged with poor prognosis and that the family was aware and understood the gravity of the patient's condition at the time of discharge. There were 13 patients discharged in stable contition to home health services or skilled nursing facilities. One patient's cause of death was not listed as the same cause of the last hospitalization. These pos-hospital deaths are unrelated to the hospitalization and are the result of management other than UPSON COUNTY HOSPITAL. A patient admitted twenty-six days prior to death with pneumonia and is killed in an automobile accident could still be counted in a hospital's mortality rate for the diagnosis of the hospitalization according to your model and method of "sophisticated statistical techniques".

6. Attached is a copy of statistics with corrections as indicated by our medical record and UB-82. You will note there are 22 errors in the ages of patients, two incorrect HIC numbers, two patients listed as a post hospital death that actually occurred during the admission and three incorrect dates of death.

As you state in your letter, "the information is useful to a wide range of groups and individuals," and you go on to list these groups and individuals. We agree in part that this can be a useful tool for analyzing patterns of practice by professional groups and may be of some value to administrative health care personnel; however, we cannot agree that it has any place or serves any purpose for health care consumers.

The results of the "sophisticated statistical technique" used does not educate the health care consumer and enable the consumer to ask questions of hospitals and physicians which will help them make a more informed decision about their health care needs.

It only confuses the issues and is a disservice to the Medicare recipient. It instills fear and mistrust in the consumer who is totally reliant on local services for health care.

The model will not suffice as a measurement of quality since it has not been validated as a useful tool. Peer Review Organizations and HCFA, along with the assistance of medical professionals will have to perfect a method that measures treatment with severity of illness. Severity of illness has been excluded from all of HCFA's guidelines too long.

The model could be used only as a statistical analysis for PRO's to review for neglect, treatment outside the standards of care and patterns of practice. Even for this purpose, the review form would have to address severity of comorbidities and complications along with treatment regimens. The listing of secondary diagnosis is a crude method to estimate expected risks of death and is questionable if these are the most significant factors. The use of ICD-9-CM codes as they are presently, will not yield the necessary information. The codes do not indicate the patient's health status or stage of illness. The model used to rate the "range of predicted mortality" assumes that all patients are similar, that all admitted with the same diagnosis, comorbidity and complication will have the same outcome. This is not valid.

There appears to be a great rush to release data on health care facilities that is not accurate nor beneficial to the consumer. A hospital's performance cannot be measured for quality by the model you are presently using.

Thank you very much for allowing us to participate in this effort to produce and publish meaningful, accurate information.

Sincerely,

Samuel S. Gregory
Administrator

SSG:asm

Enclosures

Wheeler County Hospital

P. O. BOX 398
GLENWOOD, GEORGIA 30428
PHONE: 912/523-5113

October 23, 1987

William L. Roper, M.D.
Department of Health and Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper,

On behalf of Wheeler County Hospital, a forty bed, rural, medical/surgical, acute care facility in Glenwood, Ga., Medicare Provider Number 11-0151, I appreciate the opportunity to comment on the mortality data to be released by HCFA in December 1987.

I am glad that statistics are being gathered for public release, with Wheeler County Hospital within expected range for each diagnostic category. However, the public should realize the model utilized in obtaining this data hasn't been tested and could be misinterpreted when comparing quality of care. It is essential that the public realize billing information was the sole area analyzed in obtaining this information. No severity of illness was considered, no comparison of treatment, cause of death not considered in cases where patients died following discharge. There are other discrepancies in the model which could allow confusion while analyzing the data to determine quality of care regarding mortality rates.

There are two discrepancies in the HCFA data we received. First, the twenty first patient listed, [redacted], has never been admitted to our facility, therefore our actual mortality rate is falsely elevated. Secondly, [redacted] according to your information, shows admission date 9-8-86, discharge date 9-9-86, and date of death as 9-8-86. The correct date of death is 9-9-86. It is impossible for me to understand how you obtained this information and who was responsible in assuring its accuracy. Therefore, if your figures are recalculated, we have only forty one deaths during this period instead of forty two, and only a 14% total mortality rate versus your stated 15%. This reduction would also decrease our mortality rate under the pulmonary disease category as this is the listing for the above patient who was never admitted.

While analyzing the data from your office against the medical records of each individual patient, we discovered that from 288 total cases, 41 total deaths for a 14% total mortality rate; 19 deaths or 6.5% of the total mortality rate resulted from patients the physicians left orders "DO NOT RESUSCITATE". The physicians had admitted these patients to provide for them and their families an appropriate environment for their last days in this world. Five of the nineteen "DO NOT RESUSCITATE" patients had diagnoses of metastatic carcinoma. One of the nineteen had muscular dystrophy. Nine of these nineteen patients were over 85 years old. Six-

teen other patients who died were admitted from area nursing homes. Two of these sixteen were admitted with terminal cancer.

In conclusion, of the 14% total mortality rate of patients who died within the facility or thirty days after admission, we find that 6.5% had "DO NOT RESUSCITATE" orders and 5.5% were admitted from area nursing homes. The remaining 2% were discharged alive and meeting required discharge criteria. In actuality, our total mortality rate should be 12% with the range of 8-18% predicted mortality.

The Cerebrovascular Accident category in which our actual mortality rate was at the upper limits of the predicted rates, is falsely elevated. We treated only eleven cases in this category and of this number, six patients died, and only five patients died while in the hospital. Four of the five patients who died in the hospital were 80 years of age or older. Your figures for this diagnosis show seven patients died and twelve treated. [redacted] died of sepsis, not cerebrovascular accident. This patient, according to medical records, had an old CVA but died during this admission due to sepsis. This would decrease the actual mortality rate in this category to 50%. Four of the six patients who died with this diagnosis had orders from their attending physician of "DO NOT RESUSCITATE". This order has been previously explained.

Six other patients have been misclassified. They are [redacted] All six patients were terminal with cancer, however their principal diagnoses varied from cardiac failure, respiratory failure and pneumonia, directly or indirectly resulting from their cancer.

Ten of the forty one deaths were categorized as Unknown, which means they didn't fall into any of the original sixteen categories. Therefore, our actual mortality rate for the categories analyzed would be thirty one deaths or 11% instead of 14%.

Due to your restricted length of comments, I'm unable to present the reimbursement versus cost which would allow the public to see how much money our facility lost on these patients due to the Prospective Payment System, Georgia Medical Care Foundation (PRO) and Health Care Financing Administration. Hopefully, with your next public data release, this will be possible.

I appreciate this opportunity to comment on the mortality data. I will appreciate any help you may give in adjusting your calculations and informing the public on how to analyze and utilize this information which could be misleading.

Sincerely,

David P. Crowson
Administrator

DPC/cmh

CC: Sam Nunn
Wyche Fowler, Jr.
George Mitchell
Lindsay Thomas
Charles Hatcher
Richard Ray
Pat Swindall
J. Roy Rowland
Hugh M. Gillis, Sr.
Mrs. L. L. (Pete) Phillips
Bill Longshore
All Active Staff Physicians
Joseph Parker
Clarence Boone
Martin Wilcher
Kathi Calhoun
Tom Williams

WOODSTOCK HOSPITAL

ARNOLD MILL ROAD WOODSTOCK, GEORGIA 30188 AREA CODE 404 TELEPHONE 926-5351

October 21, 1987

Office of Medical Review
Health Standards & Quality Bureau
Meadows East Building
Room 2-D2
6325 Security Bldg.
Baltimore, MD 21207

ATTN: Richard H. Husk

Of the twenty-one in the hospital deaths reported for Woodstock Hospital, Inc., fourteen of the patients and/or patient's families had requested a do not resuscitate order. Families and patients choose to view a DNR as a release, since death is as much a reality as birth, and most patients do not fear death itself as much as the indignation of deterioration, dependence and hopeless pain. Consideration must also be given to the fact that twenty-one of the 27 total deaths reported were residents of nursing homes with multiple chronic conditions as well as the multiple acute conditions which initiated hospitalization. Combined with the fact that the youngest patient was 78 years and the oldest was 101 years old, the prognosis of these patients was ambiguous upon admission.

With regards to the six deaths reported within 30 days of date discharged from the hospital, consideration must be given to the prognosis on discharge, the place patient is discharged to, and care the patient received after discharge.

The following is a listing of the diagnosis of certain individual patients that died after being admitted to the hospital.

[redacted]

Acute MI with Atrial Fib
Pneumonia LLL & RLL
Seizure Activity
D.N.R. requested by family

[redacted]

Aspiration Pneumonia
Tackycardia
Multi Decubitus with Staph
D.N.R. requested by family

[redacted]

Pulmonary Edema secondary to CHF
Pneumonia
D.N.R. requested by family

[redacted]

Septicemia
E-Coli Pneumonia
Multiple Decubitus with gram negative and gram positive
Anemia

All of the above diagnosis are serious conditions alone and become critical when a patient has multiple diagnosis of this nature.

In judging quality of care by a hospital's mortality rate, in addition to age and principal diagnosis, consideration must also be given to the patient's prognosis at the time of admission, social, economic factors, care patient receives at the place of residents, all complications and comorbidities to evaluate the severity of illness of the patient.

Thank you for the opportunity to comment.

Sincerely,

Julia Ellis

Julia Ellis
Administrator

JE:jj

Medicare Provider Number: 11-0157

RETURN RECEIPT REQUESTED - P142 517 065

Worth Community Hospital

P.O. Box 545
Camilla Highway
Sylvester, Georgia 31791-0545
(912) 776-6961

John E. Smithhisler
Administrator

October 19, 1987

TO: Health Care Financing Administration

FROM: Worth Community Hospital, Sylvester, Georgia (110134)

SUBJECT: Comments on the HCFA Medicare Mortality Data

Data Verification

The data used by the Health Care Financing Administration (HCFA) indicates that a total of 28 medicare patients admitted to Worth Community Hospital died within 30 days of admission. Of these, twenty-one (21) died while still a patient of the hospital and seven (7) died after discharge. HCFA's data and percentage rate consider only those beneficiaries whose last hospital admission in 1986 was to Worth Community Hospital--a total of 228 cases. Our own records indicate 424 medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions or transfers of individual beneficiaries to the hospital. Through the comparison of our records and the cooperation of nursing homes and another hospital, we were able to confirm that the number of deaths and dates were correct as given.

Worth Community Hospital's mortality rate fell well within the predicted range, with the exception of one case, which will be explained in the interpretive remarks.

Interpretive Remarks

The statistics given in the HCFA report may be confusing or even misleading without additional information and explanation. We will relate the interpretation directly to the data concerning the mortality rates at Worth Community Hospital.

HCFA has compiled its mortality data from admission diagnoses and not the actual cause of death. Admitting diagnoses do not reflect the severity of the illness, psychological condition, family support, nor does it show if the patient had multiple pre-existing complications or conditions. The data HCFA presented listed Worth Community Hospital as having only one case that was admitted and

An Affiliate of HCA Hospital Corporation of America

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

died of cancer. In reality, eight (8) other deaths were cancer related. But remember, the reasons for the admissions were complications such as intestinal obstruction, kidney problems, or body fluid imbalance, and therefore the admission did not fall in the cancer category. Our hospital will not show high numbers of admissions with cancer since we do not perform radiation or complicated chemo-therapy treatment. We will have more cancer related deaths than shown due to admissions for last stage cancer complications, pain control, or families that are not able to give adequate medical support.

It was also in the cancer category that our mortality rate went above the predicted range. This is the fallacy of working with percentages and small numbers. We had only one (1) patient who died following admission with the diagnosis of cancer, inferring that 100% of our cancer admissions die--predicted HCFA range is 0-99%. It is ironic that HCFA admitted in its Federal Register notice that "the smaller the number of admissions, the less reliable are the statistics." As an example of how these percentages are misleading or confusing, consider the following:

1986 Statistics for Worth Community Hospital

1. All Admissions - 1433 Mortality rate - 2.3%
2. Medicare admissions - 424 Mortality Rate - 5.1%

HCFA's cases considered

1. Medicare last admissions in 1986 - 228 Mortality Rate - 12%.
   *Medicare mortality rate excluding the seven (7) deaths after discharge - 9.2%

The HCFA mortality rate is over five (5) times greater than the (actual) mortality rate of all admissions.

Results of Preliminary Medicare Record Review

HCFA's admitting diagnoses have been divided into High Risk mortality probabilities consisting of ten (10) diagnostic categories, Low Risk mortality probabilities consisting of six (6) diagnostic categories, and "other causes" not specifically defined. Twenty-Seven (27) deaths given in our mortality data were classified in the High Risk probability. One (1) patient, age 81, was admitted in the Low Risk category with gastrointestinal disease, suffered a CVA (stroke) after the admission and died as a result of the CVA which is a High Risk probability.

Worth Community Hospital's Past, Present and Future Performance Goals

Worth Community Hospital is continually striving to give the highest quality of patient care. This is accomplished through our Quality Assurance Program, a planned process in which we set high quality standards of care and continually review our services and performance to determine whether we are meeting our standards. If review indicates we are not meeting the standards, we must determine why not, develop a plan of action for improvement and implement that plan. Follow up at a later date will reflect whether our plan has resolved the problem or must be changed in some way to be effective.

This data provided by HCFA cannot be used as a direct measure of hospital performance. It is only one tool for us to use in our efforts to improve the quality of care we provide. To attribute a patient's death to an individual hospital, based only on the fact that a patient died within thirty (30) days of the last hospital admission, does not measure the quality of care provided in that hospital or by the patient's attending physician.

J Smithhisler

John E. Smithhisler
Administrator
Worth Community Hospital

10/20/87
Date

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA: In-hospital	Deaths Reported by HCFA: Post-hospital	Deaths Verified by Hospital: In-hospital	Deaths Verified by Hospital: Post-hospital
CA -- Cancer	1			
CE -- Cerebrovascular Accidents	2	1		
GC -- Gastrointestinal Catastrophes		1		
GI -- Gastrointestinal Disease	1			
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease				
HM -- Severe Chronic Heart Disease	2	2		
HS -- Severe Acute Heart Disease	2			
ME -- Metabolic/Electrolyte Disturbances	5	1		
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease	3			
RN -- Renal Disease	2			
SE -- Sepsis				
TR -- Severe Trauma				
OP -- Ophthalmalogic Disease				
UN -- Other Diagnoses	3	2		
Total -- All Categories	21	7		

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

Hawaii

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CASTLE MEMORIAL HOSPITAL KAILUA HI 96734	HI-3 *	883	11	8-15	59	25	12-36	49	14	15-40	19	16	4-38	57	21	11-33	30	40	22-57	16	31	10-54	72	17	10-29
G N WILCOX MEMORIAL HOSPIT LIHUE HI 96766	HI-4 *	607	11	9-17	36	28	11-41	42	29	14-41	11	27	1-47	30	10	13-45	20	35	21-62	25	24	9-43	70	11	10-30
HILO HOSPITAL HILO HI 96720	HI-5 *	1254	12	8-15	94	19	14-34	83	25	17-37	39	15	8-35	63	27	13-34	41	29	22-52	35	17	6-33	95	17	10-28
HONOKAA HOSPITAL HONOKAA HI 96727	HI-6 *	106	9	6-20	5	40	7-76	5	20	5-73	3	33	1-81	9	22	5-56	5	0	6-75	4	0	1-75	7	0	2-59
KAHUKU HOSP KAHUKU HI 96731	HI-7 *	65	11	6-24	2	50	7-95	1	0	0-97	2	50	2-90	4	0	3-76	1	0	1-97	2	0	1-89	9	22	7-61
KAISER FOUNDATION HOSP HONOLULU HI 96818	HI-8	1290	11	9-15	152	16	14-31	73	15	15-36	40	13	6-32	59	14	11-32	57	37	24-50	20	20	6-43	101	17	9-26
KAPIOLANI-WOMEN'S & CHILDR HONOLULU HI 96826	HI-9 *	49	0	1-18	12	0	4-50	.	.		.	.		.	.		.	.		.	.		.	.	
KAU HOSPITAL PAHALA HI 96777	HI-10	22	14	4-35	1	100	1-97	1	0	1-97	.	.		.	.		.			3	0	2-82	3	33	1-81
KAUAI VETERANS MEMORIAL HO WAIMEA HI 96796	HI-11 *	197	17	9-20	11	18	3-50	9	56	9-63	4	0	0-75	12	0	7-54	8	38	11-69	17	29	5-44	22	27	12-49
KOHALA HOSPITAL KAPAAU HI 96755	HI-12	40	13	7-31	3	100	5-86	1	100	0-97	.	.		4	0	3-76	2	0	3-91	3	0	3-83	2	0	4-92
KONA HOSP KEALAKEKUA HI 96750	HI-13 *	409	10	9-17	32	16	11-42	17	29	12-54	10	10	2-50	27	15	9-40	8	38	13-72	13	31	5-49	48	10	8-31
KUAKINI MEDICAL CENTER HONOLULU HI 96817	HI-14	2485	14	11-17	233	15	16-31	161	20	20-35	64	19	10-32	100	32	16-34	78	36	29-52	86	17	13-35	217	30	17-31
KULA HOSPITAL KULA HI 96790	HI-15	6	33	2-63	.	.		.	.		.	.		1	0	0-99	.	.		.	.		1	100	1-97
LANAI COMM HOSP LANAI CITY HI 96763	HI-16 *	22	0	5-37	1	0	3-99	2	0	3-91	2	0	3-90	.	.			.		2	0	1-89	1	0	0-97
MAUI MEMORIAL HOSPITAL WAILUKU HI 96793	HI-17 *	1208	10	8-15	73	19	14-36	68	21	15-36	19	16	4-40	58	22	14-36	41	37	25-55	21	24	6-41	108	16	12-30
MOLOKAI GENERAL HOSPITAL KAUNAKAKI HI 96748	HI-18	69	13	7-24	2	100	1-89	1	0	1-97	1	0	0-98	8	0	4-58	1	0	1-97	.	.		13	8	7-53
QUEENS MEDICAL CENTER THE HONOLULU HI 96813	HI-19	3327	10	8-14	272	19	18-33	156	22	19-35	66	14	8-29	122	22	14-30	108	34	29-49	80	20	12-34	249	18	13-26
SAMUEL MAHELONA MEMORIAL H KAPAA, KAUAI, HI 96746	HI-20 *	30	0	0-25		.		.	.		.	.		.	.		.	.		.	.		.	.	
ST FRANCIS HOSPITAL HONOLULU HI 96817	HI-21 *	1738	12	10-17	129	17	14-32	111	22	19-37	72	4	7-28	80	26	14-33	60	37	28-54	35	11	9-39	126	17	14-31
STRAUB HOSPITAL HONOLULU HI 96813	HI-22	1736	10	8-15	143	19	18-36	78	23	18-39	33	18	6-34	62	23	13-34	69	22	27-51	26	15	5-37	79	22	12-31
WAHIAWA GENERAL HOSPITAL WAHIAWA HI 96786	HI-23	548	12	11-19	31	32	15-47	38	21	14-43	11	0	1-47	33	21	12-41	36	25	23-55	20	20	6-43	61	11	10-31

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
Name/ Location	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CASTLE MEMORIAL HOSPITAL KAILUA HI 96734	3	0	1-82	7	29	8-70	27	19	2-26	8	0	0-99	94	4	2-13	26	0	1-25	5	0	0-100	66	5	1-13	41	7	0-18
G N WILCOX MEMORIAL HOSPIT LIHUE HI 96766	7	14	3-64	9	33	11-68	17	12	1-33	1	0	0-100	72	3	2-15	21	0	1-29	4	0	0-100	32	6	1-20	34	3	0-31
HILO HOSPITAL HILO HI 96720	12	17	6-56	13	46	11-59	43	12	3-23	4	0	0-100	131	8	2-10	91	0	1-13	4	0	0-100	90	4	2-11	40	0	0-16
HONOKAA HOSPITAL HONOKAA HI 96727	1	100	0-97	.	.		1	0	0-100	.	.		8	0	0-63	1	100	0-100	.	.		14	0	0-40	1	0	0-100
KAHUKU HOSP KAHUKU HI 96731	.	.		1	100	3-99	.	.		.	.		7	0	0-63	2	50	0-96	.	.		3	33	0-94	2	0	0-100
KAISER FOUNDATION HOSP HONOLULU HI 96818	11	18	7-59	18	33	16-59	38	5	2-22	10	10	0-97	112	7	2-11	92	1	0-13	8	0	0-100	97	10	2-11	69	1	0-11
KAPIOLANI-WOMEN'S & CHILDR HONOLULU HI 96826	.	.		.	.		.	.		.	.		.	.		.	.		19	0	0-90	.	.		.		
KAU HOSPITAL PAHALA HI 96777	.	.		.	.		.	.		.	.		.	.		2	0	0-90	.	.		2	0	0-98	2	0	0-100
KAUAI VETERANS MEMORIAL HO WAIMEA HI 96796	2	0	0-94	2	50	3-91	.	.		1	0	0-100	19	5	0-30	12	0	0-44	1	0	0-100	13	8	0-40	5	20	0-71
KOHALA HOSPITAL KAPAAU HI 96755	1	0	0-97	.	.		.	.		.	.		.	.		1	0	0-99	.	.		8	0	0-56	1	0	0-100
KONA HOSP KEALAKEKUA HI 96750	6	17	3-67	6	33	10-76	3	0	0-92	.	.		28	7	3-27	46	4	0-18	3	0	0-100	41	5	1-17	3	0	0-100
KUAKINI MEDICAL CENTER HONOLULU HI 96817	42	24	10-43	24	38	19-59	99	10	4-17	15	0	0-99	283	5	3-9	133	5	1-11	6	0	0-99	166	5	2-10	109	5	0-7
KULA HOSPITAL KULA HI 96790	1	100	0-97	1	0	0-97	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
LANAI COMM HOSP LANAI CITY HI 96763	.	.		.	.		1	0	0-100	.	.		1	0	0-100	1	0	0-97	.	.		.	.		.	.	
MAUI MEMORIAL HOSPITAL WAILUKU HI 96793	12	17	5-55	19	21	19-62	30	7	2-26	7	0	0-100	174	5	2-10	47	6	1-18	6	0	0-100	86	8	2-12	49	0	0-16
MOLOKAI GENERAL HOSPITAL KAUNAKAKI HI 96748	1	100	1-97	1	0	1-97	.	.		.	.		7	14	1-57	3	0	0-86	.	.		3	0	0-93	.	.	
QUEENS MEDICAL CENTER THE HONOLULU HI 96813	21	19	7-48	22	41	21-62	97	8	3-16	35	3	0-53	245	4	3-9	177	2	1-10	21	0	0-75	402	5	2-7	221	0	0-5
SAMUEL MAHELONA MEMORIAL H KAPAA, KAUAI, HI 96746	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
ST FRANCIS HOSPITAL HONOLULU HI 96817	73	11	7-36	29	28	22-58	34	12	4-28	18	0	0-84	162	6	3-11	72	3	1-14	2	0	0-100	129	5	2-11	61	5	0-12
STRAUB HOSPITAL HONOLULU HI 96813	8	13	3-60	13	31	14-64	51	8	2-19	46	0	0-52	134	7	2-11	78	0	1-14	13	0	0-98	197	5	2-8	83	1	0-10
WAHIAWA GENERAL HOSPITAL WAHIAWA HI 96786	12	42	9-60	5	40	9-79	20	0	2-32	2	0	0-100	57	9	2-17	33	0	0-22	7	0	0-100	20	0	0-28	29	0	0-25

*Written Comments Not Submitted.

Provider 120011 - Honolulu, Hawaii October 26, 1987

KAISER FOUNDATION HOSPITALS' STATEMENT
REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987

As a group, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only 4 rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, 12 of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another 12 lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care. One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The 8 chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments. Some illustrations of omitted risk factors follow.

CA - Cancer care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the stage of the disease or whether the case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the

availability of alternate sources of such care, for example hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.

GI - Gastrointestinal disease includes the principal diagnosis of inguinal hernia (code 550). Most cases with this diagnosis are admitted for scheduled hernia repair surgery, which is very low in risk. However, some hernia cases are emergency admissions which are much higher in risk (e.g., strangulated hernias).

HS - Severe acute heart disease is likely to be dominated by acute myocardial infarction, which is generally much lower in risk than other cases in this category (e.g., ruptured aortic aneurysm, cardiac arrest).

TR - Severe trauma risk depends largely on the type, extent and combinations of injuries, none of which is distinguished by the risk model.

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Mark S. Blumberg, M.D.

2116C/29

John Waihee
GOVERNOR OF HAWAII

KENJI NAGAO
HOSPITAL ADMINISTRATOR

John Lewin, MD
DIRECTOR OF HEALTH

Jerry Walker
DEPUTY DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
KA'U HOSPITAL
P. O. BOX 40
PAHALA, HAWAII 96777

ROBERT UEOKA
HOSPITAL SYSTEM EXECUTIVE OFFICER

MEMORANDUM

October 8, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kau Hospital ID# 120018

Dear Dr. Roper:

The opportunity to express our comments regarding Mortality information about Medicare patients treated in our hospital in 1986 per attached is appreciated.

We have reviewed the attached information, and comments are as follows:

PATIENT #[redacted]A

The cause of death for patient listed should have been noted as "Astrocytoma non-resectable." The diagnosis listed was Skin Ulcer, which was actually a "complication" of the Astrocytoma.

GENERAL

Question arises as to whether or not the death certificate is being utilized to obtain information.

The survey results are a valuable tool for assisting rural hospitals evaluate patient transfer status. (Should the patient be transferred earlier?)

Should you have any questions related to the above coments, please refer them to the Chairman of Kau Hospital's Utilization Review Committee.

Sincerely,

Kenji Nagao
Administrator

sh

cc: Deputy Director of Health

HOSPITAL = 120021 KOHALA HOSPITAL KAPAAU HI

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	40	13 %	7 TO 31 %
CA - CANCER	3	100 %	5 TO 86 %
CE - CEREBROVASCULAR ACCIDENTS	1	100 %	0 TO 97 %
GU - UROLOGIC DISEASE	1	0 %	0 TO 99 %
HL - LOW-RISK HEART DISEASE	8	0 %	0 TO 56 %
HM - SEVERE CHRONIC HEART DISEASE	4	0 %	3 TO 76 %
HS - SEVERE ACUTE HEART DISEASE	2	0 %	3 TO 91 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	3	0 %	3 TO 83 %
OP - ORTHOPEDIC DISORDERS	1	0 %	0 TO 100 %
PN - PULMONARY DISEASE	2	0 %	4 TO 92 %
RN - RENAL DISEASE	1	0 %	0 TO 97 %

The percentage of mortality for Cancer cases is disproportionatly high because Kohala Hospital is a Primary Care Provider and thus the cases are referals of terminally diagnosed patients.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

KUAKINI MEDICAL CENTER
347 NORTH KUAKINI STREET / HONOLULU, HAWAII 96817
TELEPHONE 536-2236

October 26, 1987

OFFICERS

GARRET S. HOKADA
Chairman

ROY I. IRITANI, M.D.
1st Vice Chairman

DONALD I. DOI
2nd Vice Chairman

TAN TEK LUM
Secretary

DENIS C.H. KAM
Treasurer

DIRECTORS

HOALIKU DRAKE

FRANCIS S. FUJIOKA

CHUCK Y. GEE

MELVYN M. KANESHIRO, M.D.

ISAAC A. KAWASAKI, M.D.

SEIJI MOTOKI

STANLEY Y. MUKAI

PAULINE F. SIEFERMANN

DWAYNE STEELE

PRESIDENT

MASAICHI TASAKA

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D. C. 20201

Dear Dr. Roper:

Kuakini Medical Center (KMC), Medicare Provider 120007, is providing comments to the mortality data scheduled for publication. Appropriate comments contained in the attached paper outline specific clinical and demographic determinants which contribute to the mortality rates and are not included in the HCFA calculations. Comments are specific to high-risk categories of Severe Chronic Heart Disease (HM) and Pulmonary Disease (PN).

At this time, we would like to bring your attention to the concern regarding the distribution of this information to facilities. KMC received its mortality rates for Medicare admissions on October 12, 1987 while all other facilities in Hawaii received their data in late September. Only after a telephone call to your offices requesting resubmission of the data package did we receive the information through express mail. To date, we are still unable to confirm the receipt of the initial mailing.

Upon eventual receipt of the requested package, we noted that specific patient information was provided and that confidentiality is at stake in the event that the initial HCFA mail out is inadvertently sent to the wrong party. We, therefore, suggest that future releases be processed by certified mail to not only insure an adequate review period for the recipients, but more importantly, to avoid a compromise of patient confidentiality.

Fortunately, despite the delay in reviewing our data, we were able to formulate comments as indicated. However, we feel that because we were not afforded the actual 30-day period to comment, we could not conduct a more comprehensive analysis of all significant factors.

Sincerely,

Darryl N. Ing
Vice President

DNI:JK:cs

COMMENTS ON THE HCFA MORTALITY DATA
Kuakini Medical Center
Medicare Provider 120007

I. Introduction

In order to fully understand the 1986 Medicare mortality data released for Kuakini Medical Center, we have prepared the following comments as an adjunct to the data when reviewing the various rates in the selected disease categories.

Our comments are relative to two (2) areas, Interpretive Remarks, which explain specific factors we feel contribute to the statistical outcome of the rates themselves, and Comprehensive Quality Assurance Program, which describes KMC's internal programs instrumental in assessing the quality of health care delivery.

II. Interpretative Remarks

Specific comments address two (2) categories: Severe Chronic Heart Disease (HM) and Pulmonary Disease (PN). It is noted that both categories present actual mortality rates on the higher end of the predicted range, and therefore warrant comments relative to significant intrinsic and extrinsic factors.

Kuakini Medical Center is known in the Hawaii community as having a high percentage of Medicare patients. Specifically, Kuakini's mean age for Medicare patients in 1986 was 78 years. The mean Medicare age for patients who expired in the Pulmonary Disease category was found to be 82. Patients who expired in the Severe Chronic Heart Disease category, were identified to have a mean Medicare age of 80 years. Both categories represent a higher-than-average Medicare age group.

A. Pulmonary Disease

In this category, 18% expired after discharge from KMC, i.e., in a Skilled Nursing Facility (SNF)/Intermediate Care Facility (ICF) or at home. The mean age for this group was found to be 88, indicating that an even higher-than-average age group was transferred to a nursing home facility or discharged home. Of the 18%, 1/2 of these patients went home. It is our experience that often times patients chose to spend their remaining days in the comfort of their own home and close to their family.

Because these patients were listed with pulmonary disease as their principal diagnosis, we reviewed the secondary diagnoses and found that 58% of these patients were presented with multiple disease (more than one disease other than pulmonary) processes, i.e., were treated for a combination of cancer, kidney or cardiac symptoms, along with their primary pulmonary disease. This factor, therefore, demonstrates that a majority of patients in this category are "sicker" in general and should be categorized with a higher severity of illness.

It was also suspected that many of these patients had poor prognoses for recovery and were "No Code" status (a patient's decision to curtail resuscitation measures), a factor not included in the calculations for predicting mortality.

Upon review of this hypothesis, 92% of patients in this category were found to be "No Code" status. Consequently, we conclude that patients choosing to halt aggressive measures to needlessly prolong life will justifiably succumb to an earlier demise. This suggests that crude mortality rates can be biased, i.e., are influenced by the patient's decision to refuse treatment and not necessarily a reflection of substandard care. We propose that an adjustment to the mortality rate calculation be made to adequately reflect this component.

The immediate cause of death vs. underlying cause of death is also an important factor for consideration. For example, because it is known that advanced stage cancer patients eventually develop respiratory problems, it is conceivable that their last admission to an acute facility is primarily for treatment of their respiratory problems, although the cancer process has progressed to its terminal phase. Therefore, as patients enter their final phase of hospitalization, it is primarily for respiratory treatments. They inevitably die of a cardiopulmonary arrest, even though their underlying disease is usually not pulmonary related.

Because the statistical model only captures data from the patient's last admission, the Pulmonary Disease category does not truly reflect mortality related primarily to the disease. We found that although 84% of all cases reflect the "immediate" cause of death as cardiopulmonary arrests, 88% of all "underlying" cause of death determinations were attributed to non-pulmonary diseases.

B. Severe Chronic Heart Disease

Like the Pulmonary Disease category, a percentage of patients expired elsewhere, specifically 16%. The mean age was 87 and approximately 1/2 of these patients died at home. Similarly, the same supposition can be made that these patients chose to spend their remaining days in the comfort of their own home and close to their family.

A higher severity of illness was also identified for this category of patients as 52% of these cases had multiple disease processes. Combinations of respiratory, renal, cancer and other secondary diagnoses were found to be descriptive cases of this group.

Patient and/or family requests that no resuscitative measures be given was also a key factor in this group. Seventy-six percent were determined to be on "No Code" status, and therefore, indicative of a statistical bias of the HCFA model when patients choose to dictate the eventual outcome to their lives.

In conclusion, these Interpretive Remarks serve as critical tools to help understand the nature of the numbers used to determine Kuakini's morality rates. Because of the impact of these critical indicators upon the rates, it is evident that adjustments to the statistical methodology, specifically determination of a "No Code" status and severity of illness, should be addressed in future releases of HCFA mortality data.

II. Comprehensive Quality Assurance Program

Correlating HCFA's intent to provide the public with valuable information regarding hospitals' performances, Kuakini Medical Center has continuously supported a philosophy and mission statement relative to the assurance of quality in the furtherance of optimal patient care.

Several internal mechanisms are key components to the overall Quality Assurance program. A concurrent review system involves a 100% review of patients seen at Kuakini during intermittent days of the entire hospitalization. Mortality review is only one component of a multi-faceted in-depth review that is performed by the Peer Review Department staff. The Director of Quality Assurance, who is a physician, assists in the review process should concerns relating to patients' diagnostic and therapeutic management occur while the patient is in the hospital.

In addition to the scrutiny of concurrent review, Kuakini also requires each physician department specialty to conduct a retrospective death and complications review on 100% of all cases. Therefore, each of the cases (excluding those who expired elsewhere) which were selected according to HCFA's 30 day time interval from time of admission to expiration have already been subjected to a concurrent review process as well as a specialty peer review evaluation.

Each ancillary department (X-ray, laboratory, physical therapy, etc.) is also responsible for maintaining an ongoing quality assurance program. An overall Quality Assurance Committee reviews the activities of these ancillary departments in addition to those departments of the physician staff as a coordinating effort to achieve a hospital-wide comprehensive monitoring system.

JOHN WAIHEE
GOVERNOR OF HAWAII

ROMEL DELA CRUZ
ADMINISTRATOR

JOHN C. LEWIN, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
KULA HOSPITAL
204 KULA HIGHWAY
KULA, HAWAII 96790
PHONE: 878-1221

Ref: KH 87-10-260

October 22, 1987

Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
POB 26684
Baltimore, Maryland 21207

Gentlemen:

Subject: Hospital Mortality Information

Kula Hospital is a "hospital based" long term care facility with the following bed configuration: 95 SNF/ICF, 8 ICF/MR and 2 acute beds that are utilized by regular inpatients in need of immediate acute care.

The data presented indicates 6 Medicare admissions in 1986, of which 33% or 2 died within 30 days of admission. The ages of the patients at the time of death were 94 and 78, and the primary cause of death was HS and PN.

As a long term care facility we service primarily acute care facility discharges who are aged and whose medical conditions are generally terminal in nature. Comparing the mortality data of a hospital based long term care facility such as Kula Hospital with that of a short term acute care hospital is inappropriate and misleading without proper qualification concerning the type of facilities and patients involved. HCFA needs to address this issue in future releases of mortality information.

Very truly yours,

ROMEL DELA CRUZ
ADMINISTRATOR

RDC/jih

MOLOKA'I GENERAL HOSPITAL

October 9, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir/Madam;

Re: Hospital Mortality Data - Hospital ID Number 120009

Attached is a revised form of the mortality statistics for Molokai General Hospital.

Of the nine cases identified, only four expired in the ACUTE care short term element of our hospital, three were transferred to our ICF and SNF long term care unit and expired there, one was transferred to another acute facility and expired there, and one was discharged and expired at home. The specific cases are identified on the revised sheet.

It should be noted that all deaths occurring at Molokai General Hospital are subject to medical staff review against pre-established criteria to determine appropriateness and quality of care provided. The review of cases identified on your data sheet for this hospital revealed that there were not cost or day outliers, which would indicate that they were managed in a timely fashion to the level of care dictated by their conditions. The three patients transferred to the long term care facility were terminally ill and being treated for secondary diagnoses.

P.O. Box 408 · Kaunakakai, HI 96748 · Tel.: (808) 553-5331
A Queen's Health Systems Company

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

We are definitely concerned about the publication of this data for interpretation by the general public and what impact this will have on the hospital concerned. Additionally, we do not know what a "Predicted Mortality Rate" will signify particularly pertaining this age group. We hope the Department of Health & Human Services will provide additional information on this subject to the health care providers to answer some of our conerns before making public this mortality information.

Sincerely,

Herbert K. Yim
President/Administrator

cc: Anna Bishaw, Medical Records
JoAnn Ennis, Director of Nursing
Cindy Naiditch, Chief Finanical Officer
Stan Snodgrass, Healthcare Association of Hawaii, CEO

THE QUEEN'S
MEDICAL CENTER

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
PO Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

The Queen's Medical Center has examined your data release regarding the mortality data for our institution. The information contained therein appears to be accurate except for the dates of death for three patients who died in our facility rather than shortly after discharge as indicated by the listing. We have examined the UB-82 claims for those three patients and found that the error in date of death was not related to errors in our billing process. The discharge disposition code was correct at the time of submission to the fiscal intermediary. (Copies enclosed). We would appreciate correction of this data prior to release to the public.

We would like to include in our comments the following:

-Our inner-city teaching institution treats 17,000 in-patients per year with an over-all death rate of 3.4%.

-The average age of those Medicare patients who expired in our facility was 77.4 years.

-Our Medicare mortality rate in each category listed is at or below the mid-point in the range of HCFA predicted mortality rates.

-Sepsis (an overwhelming blood infection), is our highest category at 41%. Data shows that of 9 Medicare deaths, seven involved patients with cancer and two with end-stage renal disease.

-Although cancer is at the bottom of the predicted range, we are the principle Oncology referral center in the Pacific. As a point of reference, we provide over 23,000 radiation therapy treatments per year. The next largest provider of this service in our area performs only 4,000 treatments per year.

-The category of 'Metabolic' shows an average age of 78.3 years. Chart review shows that two-thirds of those patients had cancer and the others had chronic cardiac disease.

HCFA/EXEC.SEC.

1301 Punchbowl St. • Honolulu, HI 96813 • Tel.: (808) 538-9011
A Queen's Health Systems Company

-All the deaths in the 'Renal' category were chronically ill patients who had refused dialysis and surgical intervention. One patient transferred to a nursing care facility and one was taken home by the family.

-The 3% death rate in ophthalmologic disease represents one patient who chose to have eye surgery even though it was recommended that she not have anesthesia because of her cardiac complications.

- - - END OF COMMENTS - - -

We are looking forward to the release of this information to the public. The comparative data will help us answer the questions of those in our community who are concerned about quality health care and will assist our professional staff in planning for change and improvement where it is needed.

Sincerely,

John V. Schleif
Executive Vice-President

RM;jhw

cc: Fred A. Pritchard, President
Myron Shirasu, M.D., Chief-of-Staff

888 S. KING ST. ■ HONOLULU, HAWAII ■ 96813 ■ (808) 523-2311

Straub
CLINIC & HOSPITAL

EMERGENCY CARE
NORMAN NAKASHIMA M D
EARL A KUBOTA M D
PHILIP H DUNN M D
ELIOT A DE MELLO M D
FREDERICK M H CHING M D
GREG H HARP M D
JOHN C LE TMAN M D
LAWRENCE P PENNER JR M D
DEBORAH A P TNAM M D
ROBERT T MCMORINE M D

ALLERGY & CLINICAL IMMUNOLOGY
GEORGE M EWING M D
ROBERT THUNE M D

ANESTHESIOLOGY
WILLIAM H MONTGOMERY M D
JERRY E PRENTISS M D
RANDALL F STODDARD M D
JOSEPHINE L OMESTLE M D

CARDIOVASCULAR DISEASE
DAVID J G FERGUSSON M D
ROGER T WHITE M D
RAYMOND A WASAK M D
EDWARD N SHEN M D

CHEST DISEASES
W PHILIP JONES M D
DAVID J ANDREW M D

DERMATOLOGY
ROBERT KIM M D
ROMAN W GLAMB M D
JAY L GRELN M D

ENDOCRINOLOGY
RALPH M REDDOW M D
DAVID FITZPATRICK M D

GASTROENTEROLOGY
WILLIAM A HARTMAN M D
SAM O SUE M D
HOWARD S MINAMI M D

GENERAL SURGERY
JOHN F BALFOUR M D
EUGENE B FERRIS III M D
EDWARD BOONE M D
GEORGE C MCPHEETERS M D

GERIATRIC HEALTH SERVICES
M LOU HEFLEY M D

HEALTHING & HEALTH APPRAISAL CENTER
THOMAS M CASHMAN M D
STANLEY KARANSKY M D

INFECTIOUS DISEASES
FRANCIS D PIEN M D

INTERNAL MEDICINE
GLORIA M MADAMBA M D
STEPHEN C ARNOLD M D
JOHN V MICKEY M D
HENRY N PRESTON M D
E LYNN RAYNER M D
GEORGE B GARIS M D

NEUROLOGICAL SURGERY
WILLIAM M HAMMON M D
GONZALO G CHONG M D

NEUROLOGY
KENNETH K NAKANO M D
JAMES W PEARCE M D

NUCLEAR MEDICINE
ROBERT A NORDYKE M D
FRED I GILBERT JR M D

OBSTETRICS—GYNECOLOGY
WILLIAM H HINDLE M D
JOHN C SPANGLER M D
KENNETH A PRIETT M D
BARBARA S KITASHIMA M D

OCCUPATIONAL HEALTH
HERBERT K N LUKE M D
JAMES R LANGWORTHY M D
THOMAS M CASHMAN M D
PATRICK J BEECHER M D

ONCOLOGY—HEMATOLOGY
REGINALD HO M D
(Onc.) REUBEN C GUERRERO M D

OPHTHALMOLOGY
LEONARD S KUNINOBU M D
(Vitreo-Retina Surg.) JOHN H DROUHET M D
JORGE G CAMARA M D
RHOADS E STEVENS M D

ORTHOPEDICS
DONALD A JONES M D
ROBERT F LINDBERG M D
GERALD W MAYFIELD M D
MORRIS M MITSUNAGA M D
ROBERT J MEDOFF M D

OTOLARYNGOLOGY
TRUETT V BENNETT M D
D C NEWBOLD JR M D
T PUY KAKU M D

PATHOLOGY
L JOHN LOCKETT M D
JAMES L NAVIN M D
ROBERT C FLAIR M D

PEDIATRICS
SHIGEKO C LAU M D
KENNETH B ROBBINS M D

PEDIATRIC CARDIOLOGY
EDGAR C K HO M D

PEDIATRIC NEUROLOGY
SADA OKUMURA M D

PEDIATRIC ONCOLOGY—HEMATOLOGY
SHIGEKO C LAU M D

PERIPHERAL VASCULAR SURGERY
ROBERT L KISTNER M D
EUGENE B FERRIS III M D

PHYSICAL MEDICINE & REHABILITATION
TIMOTHY OLDERR M D

PLASTIC RECONSTRUCTIVE & MAXILLOFACIAL SURGERY
JAMES M PENOFF M D
ROBERT W SCHULZ M D
CLYDE M ISHII M D

PSYCHIATRY
WU T TSUSHIMA PhD
ANNETTE H GLICK PhD
ALAN B HAWK M D
DAVID C DES JARLAIS M D
MARK H BERNSTEIN M D
HARRY K DAVIS M D
ALFRED M ARENSDORF M D

RADIOLOGY
V R JOBE JR M D
ROBERT L MAY M D
SIDNEY S W WONG M D
MICHAEL L MCCABE M D
AVERY M FREED M D
CURT S B KAMIDA M D
DENNIS H KUMURA M D

RHEUMATOLOGY
DAVID L JOHN M D

THORACIC SURGERY
NIALL M SCULLY M D

UROLOGY
WALTER S STRODE M D

ADMINISTRATION
THOMAS L BATTISTO
M PETER HIGGINS
NATHAN K H MAU
PHILIP G NELSON
DOROTHY A PARK
EDWARD C POWERS
RICHARD V STENSON
JAMES P WALSH JR

MEDICAL ADMINISTRATION
FRANK L TABRAH M D
ALAN B HAWK M D

AIEA CLINIC
(Int Med.) JOHN T BERTHIAUME M D
(Int Med.) ROBERT L SCHIFF M D
(Ob-Gyn.) GARETH C YOKOCHI M D
(Ped.) RONALD H HINO M D
(Ped.) KENN SARUWATARI M D

FINANCIAL DISTRICT
JOSEPH A GROTE M D

HAWAII KAI CLINIC
(Ped.) KEITH MATSUMOTO M D
(Int Med.) RONALD D O MOORE M D
(Ob-Gyn.) KENNETH F PERSKE JR M D

KAILUA CLINIC
(Int Med.) STEVEN E MacBRIDE M D

KANEOHE CLINIC
(Int Med.) MELVIN K CHANG M D
(Ob-Gyn.) JANE BALL SERVICE M D
(Ped.) LYNN B YAMAGIHARA M D

Founded 1921 • Incorporated 1970

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper,

On behalf of Straub Clinic & Hospital, I would like to take this opportunity to further support the American Hospital Association's concerns identified in their letter to you dated September 14, 1987.

Although our hospital specific data appears to be accurate, we do not believe HCFA should lead the public to infer that mortality data may indicate quality of care. Of concern to us as well, is whether the model has identified all of the significant patient characteristics which would affect the death rate. The lack of severity of illness leads us to question the validity of the entire model.

We strongly support AHA's recommendation that the release of this information to the public should be accompanied by a statement regarding its appropriate use and limitations.

Straub Clinic & Hospital would also find it useful if you would provide advance notice of the actual date for release of the data to the public.

Sincerely,

Alan B. Hawk, M.D.
Medical Director

WAHIAWA GENERAL HOSPITAL
E' Ulu A Mālama Nou / Growing & Caring for You
128 Lehua Street/P. O. Box 580, Wahiawa, Hawaii 96786 Phone (808) 621-8411

October 22, 1987

William L. Roper, M.D.
ADMINISTRATOR
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

The following comments are made in response to your correspondence of 21 September, 1987. We submit them for inclusion with the HCFA mortality statistics which will be published in December, 1987.

Identification of the community served, its needs and preferences, and recognition of a firm committment to the patient's right to make informed decisions regarding his or her case management are critical issues to consider when evaluating the HCFA mortality statistics as they apply to Wahiawa General Hospital.

Medicare beneficiaries comprise approximately 35% of our case load. The Community of Wahiawa ranked second only to Honolulu major in terms of the number of elderly residing within ten Honolulu counties identified in the 1980 Census report. If one considers additionally, the percentage of elderly in adjacent areas from which our patient pool emerges, Wahiawa General Hospital is accessible as a health care provider for 28% of Oahu's elderly. Affiliation with a satelite dialysis unit of Kuakini Medical Center adds more patients with complex medical problems to a case mix with an already high severity of illness index. Patients who come to our facility for outpatient chemotherapy for cancer frequently utilize our inpatient services since they recognize benefits to be derived by admission to an environment which facilitates continuity of care by known and trusted caregivers.

Wahiawa General Hospital is a small community hospital equipped and staffed to meet our community's needs for general medical, surgical and obstetric care.

For 43 years, this hospital, its Board of Directors, its medical and professional staff have demonstrated awareness of the changing needs of this frail and aged population. Outpatient, long term and home health care are services which have been instituted to meet the need for personalized, convenient family centered health care. Voluntary JCAH accreditation, Quality Assurance and Peer Review monitoring have been established to assure provision of our best possible care. These efforts should be considered and evaluated in addition to review of mortality statistics in making judgements regarding assessments of our performances as a hospital.

We are cognizant at our mission and of the services whe choose to limit in order to guarantee quality of care.

It is our belief and our practice that patients who require sophisticated monitoring and/or 24 hour physician attendance be promptly stabilized and transferred to a facility appropriate to their need. Evidence of this is 0% mortality listed for severe trauma. This reflective of our transfer of such cases from our Emergency Department to Honolulu specialty hospitals.

Patients whose needs can be met are managed by our medical and nursing staffs and all attempts are made to include the patient in this therapeutic process. Mortality Statistics which appear on surface examination to be least favorable are actually a reflection of this cooperative approach to case management. This statistics show:

42% mortality for renal cases (5 patients expired)
40% Mortality for sepsis (2 patients expired)

Review of the medical records for these patients reveals that in each instance the patients and/or his family requested that heoric measures not be employed to delay an inevitable terminal condition. The right to die with dignity is a precious once and when this choice is made by the patient our medical staff and the staff of our facility will continue to comply with those who wishes.

As an institution, Wahiawa General Hospital recognizes the challenge of caring for the frail elderly and wishes to reiterate our committment to providing quality care to those patients we serve.

Sincerely

WAHIAWA GENERAL HOSPITAL

Kenam Kim
President

Idaho

ID-1

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ASHTON MEMORIAL HOSPITAL ASHTON ID 83420	ID-5 *	71	14	8-25	#	25	5-80	5	20	5-73	1	0	0-97	7	43	5-64	5	40	8-77	4	0	1-75	#	25	1-74
BANNOCK MEMORIAL HOSPITAL POCATELLO ID 83201	ID-6	790	12	8-16	63	27	17-41	30	30	15-47	13	38	7-53	36	22	11-39	33	33	23-56	14	21	2-42	69	10	9-29
BEAR LAKE MEMORIAL HOSPITA MONTPELIER ID 83254	ID-7 *	108	13	7-21	1	0	0-99	5	80	4-71	4	25	1-74	6	33	3-65	12	17	17-68	1	0	0-98	23	#	6-39
BENEWAH COMMUNITY HOSPITAL SAINT MARIES ID 83861	ID-8 *	171	12	7-19	6	50	5-68	7	14	8-70	4	0	2-75	3	0	2-81	4	50	7-82	9	22	3-55	24	13	9-42
BINGHAM MEMORIAL HOSPITAL BLACKFOOT ID 83221	ID-9 *	262	15	9-20	16	25	9-52	11	55	12-63	13	23	7-53	14	29	6-47	21	24	18-58	9	11	3-54	31	13	7-34
BLAINE COUNTY MEDICAL CENT HAILEY ID 83333	ID-10 *	86	10	6-21	1	100	2-98	1	0	0-97	1	100	1-97	5	20	7-75	2	50	4-92	2	0	1-89	14	14	7-50
BONNER GENERAL HOSPITAL SANDPOINT ID 83864	ID-11 *	434	13	9-18	32	31	15-48	13	23	11-58	19	16	7-44	16	25	9-50	13	23	19-68	9	11	4-56	49	27	11-35
CARIBOU MEMORIAL HOSPITAL SODA SPRINGS ID 83276	ID-12 *	80	8	7-23	2	0	0-89	2	50	1-89	1	0	0-99	#	0	4-78	#	25	5-79	7	29	6-67	13	0	4-47
CASSIA MEMORIAL HOSPITAL & BURLEY ID 83318	ID-13 *	412	13	9-18	27	26	9-42	15	33	12-56	15	20	4-44	26	31	10-42	8	38	12-71	23	13	8-43	63	16	10-31
CLEARWATER VALLEY HOSPITAL OROFINO ID 83544	ID-14 *	171	10	7-19	9	78	10-66	2	50	4-92	5	20	5-73	9	11	9-64	3	0	3-83	9	0	2-54	18	17	7-44
COMMUNITY HOSPITAL COUNCIL ID 83612	ID-15 *	1	0	0-99	.	.		.	.		.	.		.	.		.	.		.	.		1	0	0-99
COMMUNITY HOSPITAL (BOUNDA BONNERS FERRY ID 83805	ID-16	100	13	7-22	2	100	0-89	7	29	5-64	1	0	0-99	5	0	3-69	4	50	8-83	.	.		22	18	8-43
COUNCIL COMMUNITY HOSPITAL COUNCIL, IDAHO 83612	ID-17 *	56	7	7-27	.	.		2	100	6-94	.	.		3	0	5-85	.	.		2	0	1-89	7	0	7-68
EASTERN IDAHO REG'L MEDICA IDAHO FALLS ID 83401	ID-18 *	1854	9	7-13	119	15	14-33	65	31	19-42	29	14	7-36	49	20	13-37	49	39	24-52	21	14	7-43	131	21	12-28
ELMORE MEMORIAL HOSPITAL MOUNTAIN HOME ID 83647	ID-19	247	11	8-18	7	71	5-65	4	50	4-78	12	8	2-45	12	33	7-52	14	29	15-62	6	17	3-66	25	16	9-42
FRANKLIN COUNTY MEDICAL CE PRESTON ID 83263	ID-20 *	66	9	8-26	.	.		5	0	5-73	.	.		11	9	6-54	5	40	8-77	.	.		10	20	4-54
FREMONT GENERAL HOSPITAL SAINT ANTHONY ID 83445	ID-21 *	17	12	2-35	1	0	0-99	1	0	0-97	1	0	0-98	2	100	2-90	.	.		.	.		1	0	0-99
FREMONT GENERAL HOSPITAL SAINT ANTHONY, IDAHO 83445	ID-22 *	5	0	2-69	.	.		.	.		.	.		2	0	2-90	.	.		.	.		2	0	0-90
GOODING COUNTY MEMORIAL HO GOODING ID 83330	ID-23 *	156	9	7-19	12	42	15-66	4	0	6-80	3	0	0-84	3	0	1-81	2	50	3-91	1	0	0-99	19	21	5-40
GRITMAN MEMORIAL HOSPITAL MOSCOW ID 83843	ID-24 *	425	10	9-18	37	8	12-41	23	30	17-55	10	10	1-49	26	27	12-45	11	36	17-70	6	0	1-63	30	10	10-41
HARMS MEMORIAL HOSPITAL AMERICAN FALLS ID 83211	ID-25 *	66	6	7-25	.	.		2	0	3-91	1	0	1-97	3	33	3-82	1	0	2-98	1	100	3-99	14	0	6-48
HENRY L. DAY MEDICAL CENTE SILVERTON ID 83867	ID-26 *	169	17	8-20	7	43	5-65	4	25	3-76	2	0	0-92	8	25	6-61	15	53	20-67	6	50	4-67	28	14	5-33
KOOTENAI MEDICAL CENTER COEUR D'ALENE ID 83814	ID-27 *	1598	9	9-15	119	23	15-34	49	29	16-42	38	11	6-32	73	11	15-35	61	36	28-54	23	9	7-41	164	15	13-28
LOST RIVERS HOSPITAL ARCO ID 83213	ID-28	58	12	6-25	2	100	3-91	3	33	5-85	1	0	0-98	5	20	2-68	3	33	4-84	5	0	2-69	8	13	4-58
MADISON MEMORIAL HOSPITAL REXBURG ID 83440	ID-29 *	309	11	6-15	16	38	11-54	5	80	4-72	13	15	3-45	10	40	6-56	9	33	12-69	12	17	3-48	42	12	8-33
MAGIC VALLEY REGIONAL MEDI TWIN FALLS ID 83301	ID-30 *	1198	11	8-15	83	24	15-37	41	24	15-43	34	24	5-31	57	26	12-34	65	29	27-52	18	17	4-42	98	17	10-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ASHTON MEMORIAL HOSPITAL ASHTON ID 83420	1	0	0-100	1	0	0-98	1	0	0-100	.	.		3	0	0-85	.	.		.	.		8	0	0-57	1	0	0-100
BANNOCK MEMORIAL HOSPITAL POCATELLO ID 83201	5	20	3-72	3	67	4-84	24	21	2-29	.	.		104	7	2-11	22	5	0-31	12	0	0-95	75	4	1-12	51	2	0-13
BEAR LAKE MEMORIAL HOSPITA MONTPELIER ID 83254	.	.		.	.		.	.		.	.		13	8	0-47	.	.		5	0	0-100	1	0	0-100	5	0	0-98
BENEWAH COMMUNITY HOSPITAL SAINT MARIES ID 83861	1	100	1-97	1	0	1-97	4	25	0-76	.	.		14	0	1-37	2	0	0-99	3	0	0-100	10	10	1-46	16	6	0-53
BINGHAM MEMORIAL HOSPITAL BLACKFOOT ID 83221	6	0	2-66	3	67	9-90	8	25	1-53	.	.		31	13	1-21	1	0	0-99	3	0	0-100	27	4	1-23	11	0	0-87
BLAINE COUNTY MEDICAL CENT HAILEY ID 83333	.	.		.	.		.	.		.	.		12	8	0-42	4	0	0-83	.	.		10	0	0-58	3	0	0-100
BONNER GENERAL HOSPITAL SANDPOINT ID 83864	7	14	4-66	7	29	7-68	18	17	3-37	1	0	0-100	35	6	2-23	9	0	1-50	8	0	0-100	31	3	1-21	30	3	0-28
CARIBOU MEMORIAL HOSPITAL SODA SPRINGS ID 83276	.	.		.	.		1	0	1-97	.	.		9	22	0-50	2	0	0-100	2	0	0-100	7	0	0-64	2	0	0-99
CASSIA MEMORIAL HOSPITAL & BURLEY ID 83318	5	40	6-76	4	50	4-78	15	13	2-38	.	.		50	0	1-15	12	0	0-51	2	0	0-100	37	3	1-19	15	0	0-49
CLEARWATER VALLEY HOSPITAL OROFINO ID 83544	3	0	1-83	2	50	2-90	.	.		.	.		19	0	1-30	5	0	0-83	2	0	0-100	13	0	0-40	4	0	0-97
COMMUNITY HOSPITAL COUNCIL ID 83612	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
COMMUNITY HOSPITAL (BOUNDA BONNERS FERRY ID 83805	1	100	3-99	.	.		2	0	0-96	.	.		5	0	0-78	1	0	0-100	.	.		7	0	0-59	8	0	0-95
COUNCIL COMMUNITY HOSPITAL COUNCIL, IDAHO 83612	.	.		.	.		.	.		.	.		6	0	2-63	3	0	0-98	.	.		7	0	0-60	3	0	0-98
EASTERN IDAHO REG'L MEDICA IDAHO FALLS ID 83401	20	25	11-55	13	15	8-56	50	18	4-23	10	0	0-91	225	8	2-9	111	1	1-12	35	3	0-65	173	3	2-10	186	2	0-5
ELMORE MEMORIAL HOSPITAL MOUNTAIN HOME ID 83647	12	17	7-58	3	0	5-86	1	0	0-100	.	.		36	0	1-19	1	0	0-100	5	0	0-100	20	5	0-28	12	0	0-41
FRANKLIN COUNTY MEDICAL CE PRESTON ID 83263	1	100	0-97	1	0	1-97	.	.		.	.		5	0	0-78	1	0	0-100	.	.		4	0	0-89	.	.	
FREMONT GENERAL HOSPITAL SAINT ANTHONY ID 83445	.	.		.	.		.	.		.	.		.	.		.	.		1	0	0-100	2	0	0-96	5	0	0-99
FREMONT GENERAL HOSPITAL SAINT ANTHONY, IDAHO 83445	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
GOODING COUNTY MEMORIAL HO GOODING ID 83330	4	50	4-79	.	.		2	0	0-97	.	.		21	0	1-28	1	0	0-100	.	.		6	0	0-69	10	0	0-49
GRITMAN MEMORIAL HOSPITAL MOSCOW ID 83843	5	0	2-71	2	100	3-91	11	9	1-45	.	.		51	8	2-17	21	10	1-29	1	0	0-100	33	3	1-20	25	0	0-29
HARMS MEMORIAL HOSPITAL AMERICAN FALLS ID 83211	1	0	0-97	.	.		.	.		.	.		5	20	0-76	1	0	0-100	.	.		12	0	1-41	.	.	
HENRY L. DAY MEDICAL CENTE SILVERTON ID 83867	4	0	1-77	6	67	12-78	.	.		.	.		25	8	0-24	3	0	0-100	.	.		15	0	0-36	10	0	0-82
KOOTENAI MEDICAL CENTER COEUR D'ALENE ID 83814	16	25	9-55	9	33	15-73	70	4	4-20	5	0	0-100	161	5	2-10	69	0	1-14	17	0	0-96	139	3	2-10	113	1	0-7
LOST RIVERS HOSPITAL ARCO ID 83213	1	0	0-98	.	.		.	.		.	.		6	0	0-72	1	0	0-100	1	0	0-100	7	14	0-58	.	.	
MADISON MEMORIAL HOSPITAL REXBURG ID 83440	1	0	0-98	3	0	5-85	8	0	0-56	1	0	0-100	38	3	0-18	5	0	0-88	6	0	0-89	22	5	0-26	33	0	0-24
MAGIC VALLEY REGIONAL MEDI TWIN FALLS ID 83301	11	27	7-60	13	31	12-61	33	15	2-24	8	0	0-99	110	5	2-11	53	2	0-18	24	0	0-76	97	5	2-11	150	1	0-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MARSH VALLEY HOSPITAL DOWNEY ID 83234	ID-31 *	47	4	5-25	.	.		.	.		2	0	0-93	4	25	4-78	1	0	0-97	4	0	1-75	11	0	4-51
MCCALL MEMORIAL HOSPITAL MCCALL ID 83638	ID-32 *	106	6	7-22	1	100	1-97	2	50	2-90	.	.		9	0	6-59	9	11	12-69	.	.		10	0	4-53
MEMORIAL HOSPITAL WEISER ID 83672	ID-33 *	130	20	10-24	9	67	10-66	11	18	12-63	8	25	4-59	14	36	6-48	5	60	11-81	5	0	1-68	15	7	6-47
MERCY MEDICAL CENTER NAMPA ID 83651	ID-34	1346	11	9-16	71	18	15-38	51	27	19-44	33	9	6-34	77	16	14-33	59	36	27-53	18	11	6-44	106	18	14-31
MINIDOKA MEMORIAL HOSPITAL RUPERT ID 83350	ID-35 *	188	14	7-18	17	29	9-49	4	50	6-80	6	50	1-63	6	17	4-66	8	38	13-72	5	40	0-70	23	4	4-35
MORITZ COMMUNITY HOSP SUN VALLEY ID 83353	ID-36 *	135	4	3-15	4	0	1-74	1	0	0-97	4	50	1-74	5	20	2-69	5	0	5-73	4	25	2-75	8	0	4-59
ONEIDA COUNTY HOSPITAL MALAD ID 83252	ID-37 *	60	10	5-23	1	0	0-99	2	0	1-89	.	.		.	.		3	33	5-86	1	0	0-99	13	31	8-53
POCATELLO REGIONAL MEDICAL POCATELLO ID 83201	ID-38	847	9	6-13	34	18	11-42	25	44	14-49	13	8	3-44	32	31	12-42	31	52	23-57	24	0	4-36	74	19	10-30
SHOSHONE MEDICAL CENTER KELLOGG ID 83837	ID-39 *	203	16	7-18	15	47	6-47	6	50	8-73	7	14	3-60	5	80	5-72	4	25	14-89	1	0	1-97	30	10	7-35
ST ALPHONSUS REGIONAL MEDI BOISE ID 83704	ID-40	2137	9	6-13	130	8	14-32	86	23	19-39	54	19	9-32	58	24	13-35	52	48	27-54	24	13	5-38	137	16	12-27
ST BENEDICT'S FAMILY MEDIC JEROME ID 83338	ID-41 *	295	13	8-18	19	47	10-50	7	43	8-69	5	0	1-68	18	22	10-50	20	25	20-61	4	25	1-74	20	10	6-41
ST LUKE'S REGIONAL MEDICAL BOISE ID 83702	ID-42	2235	10	9-16	254	26	19-35	77	19	17-37	37	19	9-36	86	15	15-33	105	27	27-47	41	15	10-38	127	20	12-28
ST MARY'S HOSPITAL COTTONWOOD ID 83522	ID-43 *	128	9	7-19	4	75	4-77	4	0	3-76	1	0	0-97	5	0	3-69	7	43	12-75	3	0	0-83	23	13	7-41
ST. JOSEPH'S REGIONAL MEDI LEWISTON ID 83501	ID-44	1424	10	8-15	102	23	17-38	57	26	17-41	37	5	6-32	63	24	13-34	40	50	23-53	13	8	4-48	104	13	13-31
STEELE MEMORIAL HOSPITAL SALMON ID 83467	ID-45	229	10	7-17	2	100	2-89	5	40	7-76	7	14	5-65	16	13	7-47	4	0	8-83	3	0	0-85	37	14	7-33
SYRINGA GENERAL HOSPITAL GRANGEVILLE ID 83530	ID-46 *	120	16	7-21	5	40	4-72	5	80	6-75	9	22	1-52	3	0	1-81	7	29	9-70	9	22	3-54	14	14	5-47
TETON VALLEY HOSPITAL DRIGGS ID 83422	ID-47 *	61	13	6-24	2	50	4-92	4	50	4-77	1	0	0-99	3	33	2-81	4	50	10-85	3	0	0-84	2	0	0-90
TWIN FALLS CLINIC HOSPITAL TWIN FALLS ID 83301	ID-48 *	672	11	7-15	39	26	13-42	22	45	15-53	11	18	5-53	24	38	11-44	23	61	22-60	27	11	4-34	53	17	12-35
VALLEY COUNTY HOSPITAL CASCADE ID 83611	ID-49 *	33	0	2-24	.	.		1	0	0-97	.	.			.		.	.		2	0	0-92	5	0	3-70
WALTER KNOX MEMORIAL HOSPI EMMETT ID 83617	ID-50 *	209	10	7-18	9	11	3-55	5	60	6-75	6	17	6-70	10	20	6-57	3	67	5-85	7	43	6-67	31	10	9-38
WEST VALLEY MEDICAL CENTER CALDWELL ID 83605	ID-51 *	1052	11	8-15	47	19	12-38	36	22	15-44	26	15	6-37	51	18	12-36	41	41	25-56	16	25	8-50	103	18	13-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MARSH VALLEY HOSPITAL DOWNEY ID 83234	.	.		.	.		.	.		.	.		6	0	0-64	1	0	0-100	.	.		4	0	0-83	1	0	0-100
MCCALL MEMORIAL HOSPITAL MCCALL ID 83638	2	0	3-91	2	0	4-92	1	0	0-100	.	.		15	0	1-35	3	0	0-92	.	.		15	0	0-36	5	0	0-98
MEMORIAL HOSPITAL WEISER ID 83672	1	100	0-100	.	.		.	.		.	.		19	16	1-31	1	0	0-100	3	0	0-100	8	13	0-58	3	0	0-84
MERCY MEDICAL CENTER NAMPA ID 83651	7	14	11-75	10	20	11-65	36	14	4-26	9	11	0-98	157	9	3-12	87	5	2-14	17	0	0-96	86	2	2-12	95	0	0-8
MINIDOKA MEMORIAL HOSPITAL RUPERT ID 83350	5	40	2-71	2	0	1-89	2	50	0-92	.	.		23	0	1-26	2	0	0-100	3	0	0-100	14	14	0-37	11	9	0-61
MORITZ COMMUNITY HOSP SUN VALLEY ID 83353	.	.		.	.		4	0	0-80	.	.		14	7	0-40	1	0	0-100	1	0	0-100	18	0	0-31	25	0	0-45
ONEIDA COUNTY HOSPITAL MALAD ID 83252	1	0	0-97	.	.		.	.		.	.		8	0	0-53	3	0	0-88	.	.		3	0	0-93	5	0	0-100
POCATELLO REGIONAL MEDICAL POCATELLO ID 83201	5	80	11-82	1	0	1-97	21	10	1-30	6	0	0-100	97	2	1-11	36	0	0-22	4	0	0-100	74	3	1-12	124	1	0-7
SHOSHONE MEDICAL CENTER KELLOGG ID 83837	4	25	1-76	3	0	5-86	2	0	0-95	.	.		18	11	1-31	4	0	0-91	1	0	0-100	12	8	0-43	11	9	0-86
ST ALPHONSUS REGIONAL MEDI BOISE ID 83704	44	18	8-41	11	45	11-63	81	11	3-17	69	0	0-20	198	3	2-9	89	1	1-13	15	0	0-94	75	4	2-13	381	1	0-4
ST BENEDICT'S FAMILY MEDIC JEROME ID 83338	4	25	2-76	3	33	2-83	7	14	0-63	.	.		46	4	2-18	4	0	0-89	2	0	0-100	27	0	1-23	24	0	0-32
ST LUKE'S REGIONAL MEDICAL BOISE ID 83702	17	18	5-49	8	50	12-72	42	10	3-23	2	0	0-100	218	6	3-10	97	0	0-13	34	0	0-50	424	3	3-7	77	3	0-10
ST MARY'S HOSPITAL COTTONWOOD ID 83522	3	0	0-84	.	.		1	0	0-100	.	.		19	5	1-30	.	.		.	.		5	0	0-80	9	0	0-55
ST. JOSEPH'S REGIONAL MEDI LEWISTON ID 83501	9	22	10-68	15	40	14-61	61	8	3-19	7	0	0-100	165	5	3-11	77	1	1-14	21	0	0-99	103	8	2-11	121	2	0-7
STEELE MEMORIAL HOSPITAL SALMON ID 83467	5	40	7-78	6	0	7-72	1	100	0-97	.	.		29	0	1-22	4	0	0-78	1	0	0-100	21	10	1-27	20	0	0-35
SYRINGA GENERAL HOSPITAL GRANGEVILLE ID 83530	2	50	1-90	1	0	1-97	.	.		.	.		4	0	0-93	1	0	0-99	.	.		12	0	0-41	7	0	0-98
TETON VALLEY HOSPITAL DRIGGS ID 83422	.	.		2	0	4-92	.	.		.	.		3	0	0-90	6	0	0-81	.	.		11	0	0-50	2	0	0-100
TWIN FALLS CLINIC HOSPITAL TWIN FALLS ID 83301	4	0	2-76	5	0	8-78	5	0	0-72	1	0	0-100	113	4	2-11	19	0	1-31	6	0	0-100	71	4	1-13	63	0	0-13
VALLEY COUNTY HOSPITAL CASCADE ID 83611	.	.		.	.		.	.		.	.		2	0	0-100	1	0	0-100	.	.		7	0	0-78	1	0	0-100
WALTER KNOX MEMORIAL HOSPI EMMETT ID 83617	2	50	1-90	2	0	4-93	.	.		.	.		23	0	1-26	4	0	0-79	3	0	0-100	25	4	1-24	13	0	0-48
WEST VALLEY MEDICAL CENTER CALDWELL ID 83605	6	33	10-77	8	25	16-76	31	13	3-27	1	0	0-100	108	3	2-12	24	13	0-27	9	0	0-98	66	5	1-13	135	3	0-6

*Written Comments Not Submitted

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Thank you for this opportunity to comment on the mortality data for 1986 to be released by the Health Care Financing Administration this December.

Bannock Regional Medical Center is a 139 bed regional medical center which acts as a rural referral center for Southeastern Idaho. The casemix of patients seen by Bannock includes many elderly patients with major medical and surgical illnesses. BRMC is a full service medical center offering speciality care in the areas of radiation oncology and chemotherapy, major orthopedic services, medical and surgical intensive care units, and Life Flight emergency transport services. Life Flight patients are primarily hospital to hospital transfers. Bannock is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the body that establishes comprehensive standards for healthcare institutions.

The Director of Medical Records and the Director of Quality Assurance have validated that, with minor exceptions, the data is accurate.

At the direction of the Quality Assurance Committee of the medical staff, every death in this hospital is reviewed for the appropriateness of care. Quality assurance activities are hospital wide and focus on all patient areas in order that Bannock can provide high quality healthcare.

The HCFA data lists 16 diagnostic categories for mortality evaluation. Of Bannock's total Medicare cases reviewed by HCFA, 544 or 70% fell within the 16 diagnostic categories. It should be noted that the remaining 236 cases, 30% of the total Medicare caseload, produced only two mortalities for a mortality rate of less than one percent.

MEMORIAL DRIVE AT ISU CAMPUS
POCATELLO, IDAHO 83201
(208) 232-6150
BANNOCK
REGIONAL MEDICAL CENTER

Bannock supports the efforts of the Health Care Financing Administration in the area of quality assurance. We are, however, concerned that individuals will use this data by itself to make healthcare decisions for their families. We believe that several factors such as severity of illness as well as the combination of illnesses are not adequately reflected in these numbers. We encourage further research into the determination of quality but feel that this data in itself is not a true measure of the quality of healthcare provided by Bannock Regional Medical Center.

Sincerely,

Alan Stevenson

Alan Stevenson
Administrator
Bannock Regional Medical Center

BOUNDARY COUNTY Community Hospital and Nursing Home

P.O. Box 1449
551 Kaniksu Street
Bonners Ferry, Idaho 83805
(208) 267-3141

E. LOUIS KELLER, *Administrator*

HSQ

September 30, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Sir:

Thank you for sharing the mortality information with me. I do appreciate the review and time for consideration. Basically I have two concerns about the information and/or the process.

The general public does not understand enough about statistical information to decifer what you are presenting. More specifically and pertinent to this facility is that a low sample number will show poor statistical data. As a result I could conclude, from the data, that a person suffering from a cerebrovascular accident (CE) would not survive in our facility. Another similar example is Renal Disease (RN). I assure you that suffering from either condition I would not be "concerned" about being treated in Boundary County. Yet, statistically (as presented) one might consider that a poor decision.

My next point revolves around the "range of predicted mortality rates." I need more information as to the details of calculating these numbers. Specifically, I do not understand the information which shows: a 100% mortality and a predicted range of 0-89%, and a 0% mortality and a predicted range of 0-99%. Gross examination would indicate to me that the predicted range for the latter would be better.

Thank you for your time and consideration. I look forward to your response.

Sincerely,

Charles J. Bouis
Assistant Administrator
for Clinical Services

CB:rs

Elmore Medical Center Hospital District
P.O. Box H ● 895 North 6th East ● Mountain Home, Idaho 83647 ● (208) 587-8401

October 26, 1987

William D. Roper, M.D., Administrator
Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Balitmore, MD 21207

RE: Comments on the HCFA Release of Mortality Information

Dear Dr. Roper,

In reveiwing the data as it applies to our facility, we find problems in two areas. The first is with regards to patient transfers. The second, with severity of illness.

We are a small, rural hospital. We provide a limited range of services and many times are confronted with a patient that is admitted, stabilized and transferred to a larger hospital. Of the sample provided, seven percent of the deaths credited to our hospital were associated with patients that had been transferred to another hospital.

The severity of illness involves two issues. Because we are the type of facility we are, patients with progressive, terminal illnesses usually seek treatment from specialists in a metropolitan area some 40 miles away. However, many times when the disease process enters its terminal stages, the specialist instructs the patient to seek treatment locally. As a result, many of these patients become frequent users and ultimately expire. Many of them either in our facility or shortly after discharge.

We also have an attached nursing home, where upwards of 70 percent of the residents are Medicaid recipients. The acuity level of these patients is high and hospitalizations in our hospital frequent. Many of these patients suffer debilitating conditions that require hospitalization. As they grow older and weaker, the probability of death within 30 days of any particular admission increases.

As a general comment, we find this effort by your Department inconsistent and counterproductive. The apparent emphasis of the current Administration is to hold the local medical community accountable for quality care while every effort is made in Washington to curtail our ability to provide it. The preoccupation with cost to the program and the apparent conviction that everyone involved in providing care are dishonest, uncaring and fraudalent has created a very dangerous mentality. We hope that soon the "green eye shaded bean counters" will lose their stranglehold on the system and reason will prevail.

Sincerely,

Jan G. Cox
Administrator

JC/lb



Lost Rivers District Hospital

551 HIGHLAND DRIVE

BOX 145

ARCO, IDAHO 83213

October 8, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: HCFA MORTALITY DATA

During the year 1986 there were seven deaths in our hospital. Six of these deaths were in the high risk category and the seventh low risk was 92 years of age at the time of death. All of these people had a history of long term illness.

Lost Rivers Hospital is a rural, sole community healthcare facility with 8 licensed acute care and 16 long term and shelter care beds during this time frame. Statistics of this nature on such a small scale can be very misleading.

As the statistics show, we had 2 patients who died of cancer and since we usually only take care of terminal cancer patients, those were the only admissions with that diagnosis Thus the reason for 100% mortality rate in that category. All other categories are much lower than the predicted mortality rates as determined by HCFA.

Sincerely,

Martha Danz
Administrator

Copies to Idaho Hospital Association

Mercy Medical Center
1512 - 12th Avenue Road
Nampa, Idaho 83651
(208) 467-1171

October 26, 2987

William L. Roper, MD
Administrator
Healthcare Financing Administration
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Mercy Medical Center of Nampa, Idaho, Medicare Provider #13-0013, wishes to make the following comments regarding mortality information provided to us by the Healthcare Financing Administration.

It is our feeling that the methodology used for developing mortality data raises significant concerns. The methodology compares Mercy Medical Center's actual mortality with its predicted mortality rate in an effort to make a statement about differences in the quality of treatment that hospitals provide to patients. As the American Hospital Association has indicated to you, there has been no validation of the model and no demonstration that deviations from predicted mortality rates are the result of care provided. The data can easily suggest to the consumer that reliable statements about hospital quality of care are being made. It is quite possible that our facility's mortality rate is related to factors that were not considered in the model.

It is our understanding that one of the problems with the model is that HCFA gave severity of illness adjustments using comorbid conditions. Because HCFA received only five diagnosis (not all of the comorbid conditions as they are quoted) from a statistical standpoint any oversights like this actually invalidate the data. We also found in reviewing data submitted to us, one of the patients was actually counted twice. This patient was readmitted after discharge and died on the second admission.

Mercy Medical Center feels that it is important that HCFA cautions readers that the data does not provide an index to hospital performance. We also feel that HCFA should release all the technical analysis that supported the development of the model. As a health care provider we need to familarize ourself with the technical details of your methods and policy choices if we are to respond appropriately when the results of applying your methods are released to the public.

If you have any questions regarding these comments, please contact me.

Sincerely,

C. Kregg Hanson

C. Kregg Hanson
President/CEO

/dp

Pocatello Regional Medical Center
THE MED CENTER SERVING SOUTHEAST IDAHO
Richard M. Cagen, Administrator

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Thank you for the opportunity to respond to the mortality statistics for our hospital for the period of December 1, 1985 through January 31, 1987.

The Manager of Medical Records has validated that, with a few exceptions, the data is accurate. The information has also been carefully reviewed by our Administrative team, the Director of Quality Assurance/Risk Management, the DRG Coordinator and Chief of our Medical Staff.

On an ongoing basis, our hospital medical staff committees monitor every admission in the facility for appropriateness of care. We believe that our monitoring system provides us with a continuous feedback mechanism for continuing to meet and exceed quality care standards. Our process is reviewed annually at the hospital level and reaffirmed by the Joint Commission on Hospital Accreditation.

We were pleased to note that in the five categories of sepsis, gynecologic disease, urologic disease, ophthalmologic disease, and metabolic/electrolyte disturbances, Pocatello Regional Medical Center had no mortalities.

The following summarizes our findings regarding the other categories:

Renal disease: The predicted percentage of deaths in this category was reported to be a range of 11% to 82% and ours to be 80%. In actual numbers, four of our five cases in this category expired. Three of these were over age 85, and in all four cases the patients and/or families had requested no extraordinary life-saving measures to be taken (no code). PRMC operates the dialysis center for this region and hence receives a majority of the cases of end stage (terminal) renal disease for the area.

Severe acute heart disease: The predicted percentage of deaths in this category was reported to be a range of 23% to 57% and ours to be 52%. It should be noted that the majority of the 16 cases who expired were admitted during a heart attack.

Severe chronic heart disease: The predicted percentage of deaths in this category was reported to be a range of 12% to 42% and ours to be 31%. All of the 10 patients who expired were congestive heart failure patients. During the course of their hospitalization, six were listed "no code" at the request of themselves and/or their families. In addition to heart disease, several suffered from other system failures including renal disease and malignancy.

Cerebrovascular accidents: The predicted percentage of deaths in this category was reported to be a range of 14% to 49% and ours to be 44%. It should be noted one patient reported in this category has never been a patient at PRMC. Correcting for this error reduces our rate in this category to 40%. Further, four of the 10 who expired did so after being discharged from the hospital with the expectation that nothing further could be done medically to prolong their lives. These four, along with five who expired in the hospital, were under "no code" orders from the patients and/or families.

Pulmonary disease: The predicted percentage of deaths in this category was reported to be a range of 10% to 30% and ours to be 19%. Of the 13 persons who expired, there were "no code" orders on 11. The health of these elderly persons was further compromised by the fact that many suffered from other ailments as well as pulmonary disease, including cancer and chronic heart disease.

We are pleased to fall below the mean in the following categories.

Cancer: The predicted mortality for this category was reported to be a range of 11% to 42% and ours to be 18%.

Severe trauma: The predicted mortality for this category was reported to be range of 1% to 30% and ours to be 10%.

Orthopedic disorders: The predicted mortality for this category was reported to be 0 to 7% and ours to be 1%.

Low risk heart disease: The predicted mortality for this category was reported to be 1% to 12% and ours to be 3%.

Gastrointestinal disease: The predicted mortality for this category was reported to be 1% to 11% and ours to be 2%.

Gastrointestinal catastrophes: The predicted mortality for this category was reported to be 3% to 44% and ours to be 8%.

The overall 9% medicare mortality rate at PRMC falls below the mean and is well within the predicted range of 6% to 13%.

Pocatello Regional Medical Center will continue the ongoing process of quality assessment and peer review activities which are an integral part of monitoring the health care delivery system on which we pride ourselves. Analysis of these reviews is a constant endeavor to assist in identifying opportunities for improvement.

Again, thank you for the opportunity to respond to the mortality data. If you or anyone receiving this information has additional questions, we will be pleased to respond further.

Sincerely,

Richard M. Cagen
Administrator

Michael S. Baker, M.D.
Chief of Staff

Saint Alphonsus
REGIONAL MEDICAL CENTER
1055 NORTH CURTIS
BOISE, IDAHO 83706
(208) 378-2121

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

RE: Medicare Provider Number 13-0007

Dear Dr. Roper:

Thank you for the chance to respond to the Health Care Financing Administration's (HCFA) mortality data. Providing high quality patient care is our highest concern.

Though our actual mortality rates compare favorably to "predicted mortality rates" for the disease categories described, the use of these rates as an indicator of quality of care at different hospitals is misleading. Mortality rates, by themselves, do not measure quality. HCFA itself has said in the Federal Register that "the model remains simply one indicator of potential quality distinctions among hospitals."

The data does not account for the severity of a patient's illness. At Saint Alphonsus, there are two major factors that cause us to receive patients that are sicker than the "average" Medicare patient. First, we are a regional referral center. Many patients are transferred to Saint Alphonsus by other facilities in Idaho in hopes that our specialized physicians, staff and technology could save the life of a patient who could not have been saved at another facility. Second, we are a regional trauma center. This also causes us to receive patients with extremely complex needs and in life threatening conditions.

The HCFA mortality data can do no more than identify potential areas for further evaluation. At best, it can be used to better focus quality assurance activities. I assure you that the data will be used for this purpose at Saint Alphonsus.

At Saint Alphonsus, our quality assurance program evaluates the quality and appropriateness of patient care. Our goal is to identify problems and provide the opportunity to improve patient care. All patient records are screened. When potential medical care problems are identified, the patient's record is reviewed by a physician. Deaths, complications, unnecessary tests or procedures and other potential problems are reviewed and discussed in monthly medical staff department meetings with the involved physician. Corrective action is taken if problems with medical care are identified.

In addition to the Medical Staff Peer Review process, each hospital department performs ongoing monitoring of the quality of care provided in the department. Special emphasis is placed on evaluating whether the major clinical functions of the Department are within nationally accepted standards of care and whether the care is provided in a caring and concerned manner. The Quality Assurance Department monitors these hospital department quality assurance activities to make sure adequate review mechanisms are in place and that identified problems are resolved.

In-depth studies are also performed on a routine basis to monitor high risk or problem prone areas. Both the medical staff and the hospital departments are accountable to the Medical Staff Quality Assurance Committee and the Board of Trustees (through its Quality Evaluation Committee). This high-level of attention to quality assurance measures ensures the continued provision of high-quality, cost-effective, gospel-oriented care at Saint Alphonsus.

Very truly yours,

Sister Patricia Vandenberg, CSC

Sister Patricia Vandenberg, C.S.C.
President

190 East Bannock
Boise, Idaho
83702

208-386-2222

E. E. Gilbertson
President

St Luke's
Regional Medical Center

COMMENTS ON
HEALTH CARE FINANCING ADMINISTRATION
MORTALITY DATA
OCTOBER, 1987

The following comments represent the St. Luke's Regional Medical Center conclusions of the review of the Health Care Financing Administration (HFCA), mortality data; interpretation of that review; description of the unique nature of key services provided by the Medical Center; and the results the preliminary review of the HCFA patient list data in comparision to St. Luke's medical records.

The HCFA transmittal letter appropriately notes that the government cannot and does "not recommend the use of the information by itself to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals." St. Luke's strongly supports this advice for several reasons, including those outlined below regarding the potential inaccuracies in the HCFA report. More important, however, is the fact that "quality" is an inherently subjective concept. In health care, "quality" may be defined in ways ranging from regulatory and accreditation such as licensure or Joint Commission on the Accreditation of Hospitals standards; to aesthetic standards; to personal service and staff attitudes; and to outcomes such as mortality data. Statistics such as length of stay and average charges are considered in some definitions of quality. On the other hand, the use of HCFA mortality data may assist many hospitals in further refining aspects of their operations and may stimulate an additional focus in the industry's long standing quality assurance program emphasis.

HCFA data reports that 2,235 Medicare patients were admitted to St. Luke's during 1986; and that 229 of these patients died within 30 days of admission. Our review of the data provided by HFCA indicates that 153 of these patients expired while still a patient in the hospital. The remaining 76 expired after discharge from St. Luke's.

St. Luke's medical record data indicates that 2,627 medicare inpatients were served in 1986. Based on the statistical methodology used in the HCFA report the difference between the HCFA and St. Luke's totals apparently reflects those patients whose last 1986 admission was to a hospital other than St. Lukes even though they were a St. Luke's patient at some earlier point during 1986. The Medical Center has no way to verify this assumption.

The medical center records indicate that of the 153 patients identified by HFCA as dying during their admission, three were admitted in 1985 rather than 1986 ([redacted]; [redacted]; and [redacted]). The 76 patients identified as dying after discharge by HCFA cannot be verified by the Medical Center records.

For the 153 inpatient deaths as reported by HCFA nine, or 5.9%, show a different principal diagnosis or different information in the St. Luke's records than is indicated in the HCFA report. Of these nine, two are apparently the result of the Professional Review Organization not reporting the result of DRG validations to HCFA.

The St. Luke's medical records indicate that an additional 20 Medicare patients with less than 30 day lengths of stay, expired at St. Luke's during 1986 admissions. There is no apparent reason for these omissions. Since St. Luke's does not have the list of total admissions used by HCFA in its report, we must question the denominator component of the St. Luke's rates and the expected ranges as well.

Although the St. Luke's mortality data is well within the predicted ranges noted by HCFA for all diagnostic categories, adjustments in the rates based on the previously noted data discrepancies may result in both different ranges and different rates. Definitive statements cannot be made because HCFA has not shared its list of total Medicare patients, but only those reported as dying. If the overall list of patients, the diagnostic and other variables used by HCFA differs from the actual medical record data to the degree that the mortality data differs, the expected ranges and rates will certainly vary from those reported by the HCFA.

It is important to note that the St. Luke's tertiary programs in cardiovascular surgery, cardiology and oncology attract patients from a large geographic area, serving the most high risk and complex cases. Patients with other primary diagnoses, with secondary heart or cancer problems, etc., are often referred to St. Luke's as well. The cancer and heart categories show St. Luke's death rates near the low end of the range; however, these secondary conditions may well affect the rates for other primary diagnostic categories.

St. Joseph
Regional Medical Center
People committed to life

415 6th Street P.O. Box 816 Lewiston, Idaho 83501
Phone (208) 743 2511

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

The Sisters of St. Joseph, St. Joseph Regional Medical Center, and its Medical Staff are dedicated to the provision of high quality care to Medicare beneficiaries and to all patients.

Established in 1901, St. Joseph Regional Medical Center is sponsored by the Sisters of St. Joseph of Carondelet. The Medical Center serves as a regional medical center for north central Idaho and portions of eastern Washington.

Medicare has designated St. Joseph Regional Medical Center as a rural referral center. Our emergency room serves as the trauma center for the area. We are accredited by the Joint Commission on Accreditation of Hospitals, and our cancer treatment program is accredited by the American College of Surgeons. Eighty-four percent of the Medical Staff are board certified in their respective specialties.

We are supportive of the American Hospital Association, the Joint Commission on Accreditation of Hospitals, and other professional organizations in continuing to develop meaningful standards which may be used in measuring and evaluating quality. Mortality review is an important part of the comprehensive quality assurance program of the Medical Center. It is also of great benefit in teaching, continuing medical education, research, and the evaluation of patient care.

In closing, the philosophy of the Sisters of St. Joseph of Carondelet places a high value on respect for the dignity of each patient and the sacredness of all life. The Medical Center has the responsibility to preserve life from the time of conception, throughout life, until the call to eternal life through natural death.

Sincerely,

Howard A. Hayes
Administrator

J. Brent Fisher, M.D.
Chief of Staff

STEELE MEMORIAL HOSPITAL

(208) 756-4291
P. O. Box 700

SALMON, IDAHO - 83467

Kay H. Springer, R.N.
Administrator

Re: HCFA Mortality Data Provider Number:130043

Steele Memorial Hospital is a 35 bed acute care community hospital dedicated to personalized, quality patient care.

The HCFA Mortality Data for patients dying at Steele Memorial Hospital represents without exception terminally ill or chronically ill elderly patients, with acute exacerbation of illness. Of these fourteen patients, the range in ages is 65 - 93 years. The average age being almost seventy seven years. Many patients suffering from chronic illnesses, or terminal cancer or both, in addition experienced acute episodes of illness to complicate their disease process. Several patients suffered from as many as four different chronic diseases.

There were ten patients listed who died subsequent to discharge from the hospital. Two of these patients were transferred to other facilities for specialized care. Seven of the remaining chronically ill patients were transferred home or to other more appropriate levels of care. The ages in this group ranged from 71 - 91 with an average age of 81.4. The tenth patient in this group who was identified as a severe trauma patient in fact suffered from metastatic cancer.

It should be clarified that reference to 100% mortality in a given category is totally misleading due to the sample size which may represent only one patient.

Illinois

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ABRAHAM LINCOLN MEMORIAL H LINCOLN IL 62656	IL-21	707	14	9-17	34	24	12-43	16	25	11-53	19	26	9-48	64	36	14-35	21	62	20-60	17	6	5-45	83	19	12-30
ALEXIAN BROTHERS MEDICAL C ELK GROVE VILLAGE IL 60007	IL-22	1824	10	9-16	164	35	21-38	39	23	17-46	21	29	7-43	87	10	14-32	59	31	28-53	46	24	15-43	132	9	12-28
ALTON MEMORIAL HOSPITAL ALTON IL 62002	IL-23	1232	9	8-15	82	20	15-36	37	22	16-45	29	10	7-36	58	14	12-34	54	39	27-54	29	14	8-40	75	19	9-28
AMERICAN INTERNATIONAL HOS ZION IL 60099	IL-24	194	14	7-18	11	27	9-60	3	33	3-83	2	50	4-92	10	30	5-55	5	40	9-79	7	0	4-63	27	33	8-38
AUGUSTANA HOSPITAL CHICAGO IL 60614	IL-25	1001	10	10-17	77	22	16-38	38	16	15-44	39	18	10-38	44	7	13-39	24	42	22-60	21	14	7-44	96	13	14-32
BEARDSTOWN HOSPITAL BEARDSTOWN IL 62618	IL-26 *	220	13	9-20	13	46	15-64	7	14	6-65	5	20	1-68	20	20	9-45	7	29	13-76	2	50	1-89	30	10	9-38
BELMONT COMMUNITY HOSPITAL CHICAGO IL 60641	IL-27 *	509	14	8-17	31	55	16-50	12	25	10-59	11	18	4-50	44	25	13-39	13	62	16-65	16	19	6-47	41	22	11-38
BETHANY HOSPITAL CHICAGO IL 60624	IL-28	436	6	6-14	10	40	10-63	10	0	7-58	6	17	4-67	28	11	10-40	7	0	11-73	16	19	6-47	39	15	8-34
BETHESDA HOSPITAL CHICAGO IL 60645	IL-29 *	547	13	9-17	20	30	10-49	10	20	8-60	22	9	6-41	29	21	11-42	13	62	18-68	14	21	4-47	74	22	13-33
BLESSING HOSP QUINCY IL 62301	IL-30	2279	9	8-15	160	19	16-34	73	26	20-41	46	13	8-33	92	16	16-35	59	32	27-53	27	19	10-44	171	19	15-30
BROKAW HOSPITAL NORMAL IL 61761	IL-31 *	1286	10	8-15	74	18	13-35	41	29	17-45	23	22	5-38	68	21	14-35	37	30	25-57	13	15	3-47	89	17	13-31
BURNHAM HOSPITAL CHAMPAIGN IL 61820	IL-32	1179	11	9-16	73	21	18-41	40	43	17-45	29	17	8-38	71	20	14-34	36	50	24-56	26	23	11-45	72	21	13-34
CARLE FOUNDATION HOSPITAL URBANA IL 61801	IL-33	2164	10	8-15	254	17	16-32	57	19	16-40	61	11	9-31	65	26	16-37	67	39	27-52	32	25	10-41	127	25	14-31
CARLINVILLE AREA HOSPITAL CARLINVILLE IL 62626	IL-34 *	447	12	8-16	8	13	5-61	19	26	13-53	8	25	7-65	27	33	10-41	8	38	14-73	5	40	1-68	59	12	11-33
CARMI TOWNSHIP HOSPITAL CARMI IL 62821	IL-35	540	12	10-18	15	33	14-60	24	21	14-50	8	13	3-58	38	13	13-40	22	64	23-62	9	22	5-59	52	13	12-35
CENTRAL COMMUNITY HOSPITAL CHICAGO IL 60636	IL-36 *	417	12	9-18	27	26	9-41	11	18	6-55	9	33	4-56	47	15	12-37	24	58	24-62	21	14	4-38	29	14	10-41
CENTRAL COMMUNITY HOSPITAL CLIFTON IL 60927	IL-37 *	142	11	8-20	5	0	3-70	10	30	8-60	.	.		12	33	8-55	4	50	10-85	9	0	2-53	12	25	7-54
CENTRAL DUPAGE HOSP WINFIELD IL 60190	IL-38	2285	11	8-15	153	29	14-32	91	36	20-39	63	13	9-30	133	27	16-31	58	41	27-53	38	42	12-41	181	15	12-26
CENTREVILLE TOWNSHIP HOSPI CENTREVILLE IL 62207	IL-39 *	191	13	7-18	5	80	6-75	6	50	7-72	2	50	3-91	24	25	9-41	8	50	10-68	7	14	2-60	16	6	4-41
CHICAGO OSTEOPATHIC MEDICA CHICAGO IL 60615	IL-40	1899	14	9-15	117	27	18-38	59	34	19-43	34	38	8-36	104	15	15-32	37	49	26-57	60	28	10-35	168	27	14-28
CHRIST HOSPITAL OAK LAWN IL 60453	IL-41	5206	13	10-16	396	31	17-31	171	30	20-35	130	19	13-30	267	20	17-29	239	34	32-47	113	19	11-30	454	26	18-29
CLAY COUNTY HOSP FLORA IL 62839	IL-42	258	20	12-23	11	64	10-61	11	18	12-63	3	0	0-84	17	24	10-51	24	50	23-61	19	26	8-47	32	28	10-39
COLE HOSPITAL CHAMPAIGN IL 61820	IL-43 *	322	14	8-18	19	53	13-54	8	25	9-67	6	17	3-66	28	36	10-40	8	50	14-73	7	14	4-64	26	8	6-36
COLUMBUS HOSPITAL CHICAGO IL 60614	IL-44	1762	14	10-16	140	28	20-38	59	22	20-44	44	20	10-36	90	14	14-32	32	38	26-60	50	30	14-41	139	32	15-31
COMMUNITY GEN HOSP STERLING IL 61081	IL-45 *	1309	12	9-16	87	26	17-38	37	22	17-47	26	8	8-40	109	34	15-32	48	42	26-54	31	6	5-34	106	15	10-26
COMMUNITY HOSP EAST ST LOUIS IL 62201	IL-46 *	226	10	7-18	3	33	8-89	8	38	8-65	5	40	4-72	17	24	8-46	6	33	6-70	19	32	12-53	12	8	3-45

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ABRAHAM LINCOLN MEMORIAL H LINCOLN IL 62656	5	20	4-74	10	40	15-71	38	3	4-25	.	.		86	6	2-12	39	5	1-20	7	0	0-100	45	4	2-17	31	3	0-20
ALEXIAN BROTHERS MEDICAL C ELK GROVE VILLAGE IL 60007	15	20	10-58	14	36	23-73	30	7	3-28	3	0	0-100	209	3	3-10	63	3	1-16	9	0	0-99	149	5	2-9	77	5	1-10
ALTON MEMORIAL HOSPITAL ALTON IL 62002	5	20	1-71	8	38	11-71	56	5	3-20	13	0	0-99	146	7	2-10	38	3	1-20	13	0	0-99	97	4	2-12	132	0	0-6
AMERICAN INTERNATIONAL HOS ZION IL 60099	3	67	1-82	3	33	5-86	6	17	0-65	.	.		15	0	1-35	9	0	0-58	1	0	0-100	13	[illegible]	1-39	33	3	0-47
AUGUSTANA HOSPITAL CHICAGO IL 60614	7	29	4-66	23	43	23-64	15	7	2-38	4	0	0-100	96	7	2-12	56	7	3-19	4	0	0-100	75	4	2-13	62	0	0-12
BEARDSTOWN HOSPITAL BEARDSTOWN IL 62618	2	0	2-91	3	0	2-82	5	0	0-74	.	.		14	0	0-38	11	0	0-47	3	0	0-100	16	19	1-34	7	0	0-98
BELMONT COMMUNITY HOSPITAL CHICAGO IL 60641	3	33	1-82	5	80	15-86	7	14	0-58	.	.		74	3	1-13	19	0	0-32	5	0	0-100	38	8	1-19	23	0	0-40
BETHANY HOSPITAL CHICAGO IL 60624	4	0	1-76	6	67	14-82	3	0	0-86	5	0	0-100	31	3	2-23	22	5	1-28	2	0	0-100	32	0	1-20	18	0	0-54
BETHESDA HOSPITAL CHICAGO IL 60645	8	25	7-67	9	44	12-69	7	14	0-59	1	0	0-100	47	6	1-17	41	10	3-23	3	0	0-100	57	0	1-15	21	5	0-36
BLESSING HOSP QUINCY IL 62301	29	10	10-47	13	15	14-63	60	2	4-20	73	0	0-12	259	6	2-9	117	3	2-14	7	0	0-100	150	7	2-10	162	1	0-6
BROKAW HOSPITAL NORMAL IL 61761	8	25	8-69	10	30	14-70	43	12	4-24	2	0	0-100	147	7	3-11	33	3	1-22	13	0	0-98	57	2	1-14	104	1	1-8
BURNHAM HOSPITAL CHAMPAIGN IL 61820	7	71	6-69	6	0	10-76	43	7	3-23	8	0	0-98	109	1	2-11	28	4	1-24	9	0	0-99	139	6	3-11	89	2	0-9
CARLE FOUNDATION HOSPITAL URBANA IL 61801	16	31	6-51	21	29	18-60	49	0	3-21	89	0	0-9	216	7	3-10	84	0	1-14	26	4	0-41	189	3	2-9	214	1	0-5
CARLINVILLE AREA HOSPITAL CARLINVILLE IL 62626	5	20	2-71	3	33	6-87	14	21	2-39	.	.		56	5	1-15	19	5	1-31	8	0	0-94	28	4	1-22	15	0	0-41
CARMI TOWNSHIP HOSPITAL CARMI IL 62821	14	14	10-59	5	20	12-83	4	25	2-74	.	.		89	9	2-13	13	8	1-40	1	0	0-100	68	1	2-13	22	0	0-32
CENTRAL COMMUNITY HOSPITAL CHICAGO IL 60636	5	60	11-82	3	0	5-86	4	0	0-77	3	0	0-100	38	5	1-19	14	0	0-39	5	0	0-99	32	6	1-20	38	0	0-23
CENTRAL COMMUNITY HOSPITAL CLIFTON IL 60927	.	.		1	0	1-97	.	.		.	.		17	0	0-33	4	0	0-83	.	.		12	0	0-42	5	0	0-84
CENTRAL DUPAGE HOSP WINFIELD IL 60190	19	11	6-48	34	15	21-55	82	7	4-18	136	1	0-7	229	3	3-10	114	2	1-12	20	0	0-87	161	6	2-9	170	1	0-6
CENTREVILLE TOWNSHIP HOSPI CENTREVILLE IL 62207	3	0	2-82	3	33	5-86	3	0	0-85	.	.		16	0	0-38	14	7	0-38	1	0	0-100	27	0	1-22	14	0	0-55
CHICAGO OSTEOPATHIC MEDICA CHICAGO IL 60615	17	12	7-52	32	41	19-54	31	13	2-25	11	0	0-100	178	8	3-11	78	9	3-17	14	0	0-70	198	5	3-10	124	1	0-7
CHRIST HOSPITAL OAK LAWN IL 60453	31	23	8-44	102	43	26-50	129	10	6-18	16	0	0-86	479	4	3-9	187	9	2-12	33	0	0-57	497	3	3-7	272	3	1-5
CLAY COUNTY HOSP FLORA IL 62839	3	0	7-89	7	29	14-78	4	25	1-74	.	.		23	4	1-26	2	0	0-96	3	0	0-100	22	18	1-27	11	0	0-86
COLE HOSPITAL CHAMPAIGN IL 61820	4	25	2-76	2	50	4-92	19	5	2-33	.	.		52	6	3-19	9	0	0-54	2	50	0-100	23	9	1-26	32	0	0-22
COLUMBUS HOSPITAL CHICAGO IL 60614	13	0	5-54	18	39	19-63	31	10	5-31	48	0	0-24	167	8	3-11	100	11	3-16	12	0	0-82	152	4	2-10	95	1	0-8
COMMUNITY GEN HOSP STERLING IL 61081	19	16	7-50	11	18	14-67	37	11	4-26	10	0	0-98	174	9	3-11	53	4	1-17	14	0	0-99	111	3	2-11	93	1	0-8
COMMUNITY HOSP EAST ST LOUIS IL 62201	3	0	0-89	4	0	7-81	.	.		7	0	0-100	11	0	1-44	8	0	0-61	1	0	0-100	12	0	0-31	5	0	0-98

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
COMMUNITY HOSPITAL GENEVA IL 60134	IL-47 *	676	11	8-16	44	16	8-34	35	31	17-47	13	15	5-50	41	10	12-38	26	31	20-57	21	19	6-42	50	26	11-34
COMMUNITY HOSPITAL OF OTTA OTTAWA IL 61350	IL-48	945	14	10-17	53	36	17-43	40	38	17-46	23	17	9-44	48	25	12-36	43	37	25-54	23	26	9-45	97	16	11-29
COMMUNITY MEMORIAL HOSPITA MONMOUTH IL 61462	IL-49 *	565	13	10-18	23	35	10-46	26	19	15-50	19	5	6-42	39	21	11-37	26	54	28-65	20	20	7-44	59	15	11-33
COMMUNITY MEMORIAL HOSPITA STAUNTON IL 62088	IL-50 *	379	13	8-17	21	57	13-51	19	32	12-52	6	17	2-64	23	30	11-45	14	36	16-63	8	0	1-56	34	32	10-38
CONDELL MEM HOSP LIBERTYVILLE IL 60048	IL-51	1184	14	11-18	86	30	18-40	48	23	18-44	37	19	7-34	85	24	14-33	53	43	27-54	38	26	12-42	109	24	12-29
COOK COUNTY HOSPITAL CHICAGO IL 60612	IL-52	2180	7	7-14	166	15	19-36	42	21	15-42	28	21	5-35	154	9	14-28	26	50	20-57	51	14	12-38	192	9	12-26
COPLEY MEMORIAL HOSPITAL AURORA IL 60507	IL-53 *	1601	13	10-17	164	27	18-36	71	15	19-41	33	18	8-36	97	29	15-32	58	50	27-53	25	16	6-39	110	21	13-31
CRAWFORD MEMORIAL HOSPITAL ROBINSON IL 62454	IL-54	636	15	9-17	22	50	12-49	18	67	14-55	23	22	4-36	44	27	11-36	30	40	24-59	23	22	6-40	54	7	10-32
CROSSROADS COMMUNITY HOSPI MT VERNON IL 62864	IL-55	388	11	8-17	21	33	10-47	10	20	8-59	6	17	2-63	27	19	10-42	13	31	18-67	8	13	5-61	45	18	8-31
DECATUR MEMORIAL HOSPITAL DECATUR IL 62526	IL-56	2679	12	10-16	264	32	21-37	89	24	18-38	65	20	13-35	123	24	17-33	79	42	29-52	38	16	10-38	208	18	14-28
DELNOR HOSPITAL ST CHARLES IL 60174	IL-57 *	579	13	9-17	40	20	13-41	21	38	14-52	11	9	4-51	39	15	12-39	22	41	21-61	19	21	6-43	53	32	10-33
DOUGLAS COUNTY JARMEN MEM TUSCOLA IL 61953	IL-58	230	20	9-20	14	29	10-56	6	50	6-70	2	0	0-90	13	46	8-53	8	63	19-80	10	10	2-50	40	35	12-39
DR JOHN WARNER HOSPITAL CLINTON IL 61727	IL-59 *	426	12	9-18	14	36	14-62	19	53	16-57	7	0	6-66	21	29	13-50	12	33	17-68	1	0	0-98	56	14	10-33
EDGEWATER HOSPITAL CHICAGO IL 60660	IL-60 *	1612	13	11-18	71	32	17-40	56	29	20-45	53	19	11-35	88	23	15-33	66	38	30-55	29	14	12-45	137	24	18-35
EDWARD A UTLAUT MEM HOSP GREENVILLE IL 62246	IL-61 *	419	15	11-20	20	30	10-49	22	23	14-51	4	0	0-76	34	26	11-39	26	42	25-62	15	7	6-49	51	25	10-34
EDWARD HOSPITAL NAPERVILLE IL 60566	IL-62	978	13	9-17	47	34	17-45	52	21	17-42	18	11	4-41	63	16	14-35	30	50	22-56	22	23	7-43	109	30	15-33
ELGIN STATE HOSP-MED SUR ELGIN IL 60120	IL-63 *	49	0	0-19	.	.		.	.		.	.		.	.		.	.		1	0	0-100	1	0	0-99
ELMHURST MEMORIAL HOSPITAL ELMHURST IL 60126	IL-64	3061	13	10-17	233	26	18-34	134	19	21-38	60	22	13-36	171	20	14-28	103	43	31-51	73	15	13-37	303	21	14-26
EUREKA HOSPITAL EUREKA IL 61530	IL-65 *	264	18	9-20	12	42	8-56	15	27	11-55	14	14	3-44	10	10	7-59	11	73	22-76	5	20	2-69	34	29	9-37
EVANSTON HOSPITAL GLENBROO EVANSTON IL 60201	IL-66	4759	9	9-15	411	18	17-31	136	21	22-38	129	16	11-28	186	16	17-30	169	31	33-50	66	26	11-35	336	19	16-28
FAIRBURY HOSPITAL FAIRBURY IL 61739	IL-67 *	324	12	11-21	13	31	13-61	16	13	13-57	12	8	5-51	29	21	13-45	13	62	22-72	14	0	3-44	52	21	14-38
FAIRFIELD MEMORIAL HOSPITA FAIRFIELD IL 62837	IL-68 *	371	13	9-18	18	17	14-56	17	29	9-50	10	0	1-49	22	27	9-43	17	29	18-62	14	29	8-53	42	24	9-34
FAYETTE COUNTY HOSPITAL VANDALIA IL 62471	IL-69 *	403	13	10-19	13	38	5-50	9	33	9-63	10	20	6-56	23	26	11-46	27	37	26-63	24	4	6-39	51	24	12-36
FERRELL HOSPITAL INC ELDORADO IL 62930	IL-70 *	539	16	11-19	31	42	17-51	15	7	16-62	5	40	2-68	33	27	15-45	25	64	26-64	16	31	4-44	61	23	13-35
FOSTER G MCGAW HOSPITAL MAYWOOD IL 60153	IL-71	3127	8	7-13	283	21	18-33	64	14	16-38	59	14	9-31	131	23	15-31	87	37	27-49	33	12	8-38	126	20	12-28
FRANCISCAN MEDICAL CENTER ROCK ISLAND IL 61201	IL-72	1682	10	7-14	86	30	16-37	43	23	17-44	31	23	6-34	67	25	13-33	49	27	24-52	41	17	8-35	144	19	14-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
COMMUNITY HOSPITAL GENEVA IL 60134	7	29	4-66	7	29	9-71	30	7	2-26	3	0	0-100	97	2	2-12	17	0	0-35	9	0	0-100	72	3	1-13	37	0	0-21
COMMUNITY HOSPITAL OF OTTA OTTAWA IL 61350	12	33	8-60	8	38	13-73	39	8	4-25	9	0	0-99	109	6	2-12	45	7	3-22	3	0	0-100	40	5	2-19	56	5	0-12
COMMUNITY MEMORIAL HOSPITA MONMOUTH IL 61462	4	75	6-81	8	13	15-75	24	8	2-28	.	.		76	4	1-13	13	0	2-42	5	0	0-100	50	8	1-15	35	3	0-19
COMMUNITY MEMORIAL HOSPITA STAUNTON IL 62088	4	0	2-77	1	0	1-97	8	13	1-53	1	0	0-100	38	5	1-20	20	0	1-30	5	0	0-100	27	0	1-23	25	0	0-35
CONDELL MEM HOSP LIBERTYVILLE IL 60048	11	27	8-61	23	30	20-60	43	12	3-23	8	0	0-98	106	6	3-14	48	4	1-18	3	0	0-100	76	5	2-13	81	2	1-10
COOK COUNTY HOSPITAL CHICAGO IL 60612	26	19	8-47	6	50	9-75	22	14	2-31	61	0	0-22	171	6	2-10	154	3	1-11	28	0	0-34	184	3	2-8	103	1	0-8
COPLEY MEMORIAL HOSPITAL AURORA IL 60507	18	33	7-50	10	50	14-70	49	6	6-26	3	0	0-100	162	2	2-11	93	10	2-14	14	0	0-74	111	2	2-11	138	1	0-6
CRAWFORD MEMORIAL HOSPITAL ROBINSON IL 62454	9	33	6-63	9	56	19-77	5	0	2-68	1	0	0-100	84	5	1-12	12	17	2-43	5	0	0-100	72	1	2-13	20	0	0-33
CROSSROADS COMMUNITY HOSPI MT VERNON IL 62864	3	33	1-82	9	11	13-71	9	33	1-50	1	0	0-100	50	2	2-17	13	15	1-40	6	0	0-100	21	0	1-28	25	0	0-32
DECATUR MEMORIAL HOSPITAL DECATUR IL 62526	16	25	15-63	20	35	21-63	82	6	5-21	32	3	0-40	288	5	3-10	125	6	2-12	29	0	0-59	169	4	3-10	197	2	0-5
DELNOR HOSPITAL ST CHARLES IL 60174	3	67	1-82	7	43	8-70	22	14	3-32	3	0	0-99	71	6	2-15	16	19	0-37	7	0	0-100	50	8	1-16	49	0	0-14
DOUGLAS COUNTY JARMEN MEM TUSCOLA IL 61953	6	67	11-78	1	0	0-98	7	29	0-60	.	.		36	3	1-19	15	0	0-37	1	0	0-100	12	17	0-42	10	0	0-70
DR JOHN WARNER HOSPITAL CLINTON IL 61727	3	33	2-83	7	57	17-81	7	29	0-60	.	.		52	4	2-18	21	0	2-30	2	0	2-89	49	6	2-17	32	3	0-21
EDGEWATER HOSPITAL CHICAGO IL 60660	8	13	8-69	37	38	27-60	27	22	5-33	23	4	0-55	149	2	3-12	53	6	2-19	7	0	0-61	219	3	3-9	66	2	1-11
EDWARD A UTLAUT MEM HOSP GREENVILLE IL 62246	13	38	9-60	6	50	7-72	18	11	1-33	1	0	0-100	39	0	1-18	13	0	0-47	6	0	0-100	33	3	1-21	7	0	0-92
EDWARD HOSPITAL NAPERVILLE IL 60566	11	9	11-65	16	38	18-64	34	15	2-24	2	0	0-100	116	5	2-11	33	3	2-23	13	0	0-94	88	6	2-12	87	2	0-9
ELGIN STATE HOSP-MED SUR ELGIN IL 60120	.	.		.	.		.	.		.	.		.	.		.	.		1	0	0-100	1	0	0-100	2	0	0-100
ELMHURST MEMORIAL HOSPITAL ELMHURST IL 60126	24	38	11-52	62	32	24-51	82	13	6-21	8	0	0-100	357	6	3-9	153	7	3-13	14	0	0-96	239	4	2-8	146	2	0-6
EUREKA HOSPITAL EUREKA IL 61530	5	40	6-76	6	67	15-82	13	31	1-40	.	.		29	0	0-22	12	0	0-51	2	0	0-100	27	7	1-23	9	0	0-83
EVANSTON HOSPITAL GLENBROO EVANSTON IL 60201	31	6	10-47	24	33	23-63	164	9	6-17	70	0	0-13	493	4	3-8	182	5	2-12	16	0	0-75	386	3	3-8	321	1	1-4
FAIRBURY HOSPITAL FAIRBURY IL 61739	3	33	3-84	.	.		6	0	1-62	.	.		35	3	0-19	8	0	0-66	5	0	0-93	27	0	1-24	13	8	0-62
FAIRFIELD MEMORIAL HOSPITA FAIRFIELD IL 62837	8	25	3-61	5	0	9-79	8	38	1-54	.	.		50	2	1-16	11	9	0-45	9	0	0-81	31	3	1-21	15	0	0-41
FAYETTE COUNTY HOSPITAL VANDALIA IL 62471	1	0	0-99	6	17	7-73	14	7	3-43	5	0	0-99	49	4	1-16	31	6	1-23	.	.		47	2	1-17	7	14	0-83
FERRELL HOSPITAL INC ELDORADO IL 62930	12	25	7-57	7	43	19-83	9	0	1-50	.	.		62	6	2-15	43	2	2-21	5	0	0-100	58	12	2-16	15	0	0-42
FOSTER G MCGAW HOSPITAL MAYWOOD IL 60153	21	10	4-44	8	50	14-75	24	17	1-27	35	0	0-35	197	8	2-9	111	5	1-12	27	0	0-87	746	3	3-7	201	1	0-5
FRANCISCAN MEDICAL CENTER ROCK ISLAND IL 61201	10	30	5-59	16	63	15-61	39	3	3-23	10	0	0-94	155	5	2-9	56	4	2-18	13	0	0-100	107	5	2-10	80	8	0-9

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
FRANK CUNEO MEMORIAL HOSPI CHICAGO IL 60613	IL-73 *	408	8	7-16	10	10	7-59	4	0	6-80	3	0	3-83	11	27	7-55	7	43	10-72	4	0	1-74	39	23	11-38
FRANKLIN BLVD COMMUNITY HO CHICAGO IL 60624	IL-74	58	3	3-20	1	0	0-97	1	0	0-97	1	100	0-98	5	0	1-67	1	0	1-97	3	33	1-81	7	0	2-59
FRANKLIN HOSPITAL BENTON IL 62812	IL-75 *	671	16	10-18	42	36	15-43	37	35	16-46	5	20	1-69	63	25	15-36	40	50	25-55	11	55	6-54	68	24	10-30
FREEPORT MEMORIAL HOSPITAL FREEPORT IL 61032	IL-76	1617	12	8-15	119	24	13-32	60	33	19-43	40	13	7-33	89	25	14-32	52	48	25-52	52	17	11-37	130	15	12-27
GALENA-STRAUSS HOSPITAL GALENA IL 61036	IL-77	137	11	9-22	5	40	6-75	8	0	9-67	5	0	0-69	7	14	6-66	7	43	16-79	5	80	5-74	18	11	8-47
GALESBURG COTTAGE HOSPITAL GALESBURG IL 61401	IL-78	1563	12	9-16	113	31	18-37	47	30	18-44	35	17	10-39	89	33	16-35	37	38	24-55	31	16	9-40	119	22	15-32
GIBSON COMMUNITY HOSPITAL GIBSON CITY IL 60936	IL-79 *	317	12	9-19	29	24	13-47	8	38	6-62	10	20	5-55	27	15	13-45	9	33	19-76	5	0	0-70	27	19	10-43
GLENDALE HEIGHTS COMMUNITY GLENDALE HEIGHTS IL 60137	IL-80	422	24	12-22	17	35	8-49	15	33	13-57	11	0	4-50	30	30	12-43	20	40	21-63	12	50	6-53	73	41	15-36
GOOD SAMARITAN HOSPITAL DOWNERS GROVE IL 60515	IL-81 *	1909	11	9-15	125	19	17-36	57	33	18-42	59	15	7-29	115	21	16-32	68	49	27-51	24	13	8-42	174	21	14-28
GOOD SAMARITAN HOSPITAL MOUNT VERNON IL 62864	IL-82	1430	11	9-16	76	36	19-42	36	31	17-48	16	6	5-45	66	26	14-36	37	49	27-59	52	17	11-37	141	13	14-30
GOOD SHEPHERD HOSPITAL BARRINGTON IL 60010	IL-83	987	10	10-17	61	23	17-42	25	16	13-47	31	13	9-39	57	26	14-37	37	41	25-57	25	16	10-44	103	13	12-29
GOTTLIEB MEMORIAL HOSPITAL MELROSE PARK IL 60160	IL-84	1662	10	9-16	121	26	16-35	61	30	18-42	35	17	6-33	134	18	15-30	59	42	28-54	29	14	8-39	139	18	12-28
GRAHAM HOSPITAL ASSOCIATIO CANTON IL 61520	IL-85 *	1158	12	8-15	72	26	16-39	35	49	17-48	26	0	5-35	78	28	15-34	33	48	25-59	26	23	5-36	89	11	11-30
GRANT HOSPITAL CHICAGO IL 60614	IL-86 *	2064	12	10-17	108	22	19-39	88	23	20-40	61	20	11-34	109	19	15-32	78	31	29-52	39	28	10-38	151	26	16-31
HAMILTON MEMORIAL HOSPITAL MCLEANSBORO IL 62859	IL-87 *	377	10	9-19	20	40	19-60	13	31	11-58	7	0	5-64	10	20	8-59	13	54	18-67	10	40	9-62	23	9	7-40
HAMMOND HENRY DISTRICT HOS GENESEO IL 61254	IL-88 *	402	13	9-18	18	28	8-47	14	36	10-56	12	33	5-50	25	24	11-45	28	43	24-60	7	0	1-59	34	21	10-38
HARDIN CO GEN HOSP ROSICLARE IL 62982	IL-89 *	323	11	5-14	9	44	6-59	4	25	4-77	1	100	1-97	9	44	7-60	10	50	11-65	3	33	2-82	37	19	9-35
HARRISBURG MEDICAL CENTER HARRISBURG IL 62946	IL-90 *	718	13	9-16	55	33	11-35	38	37	17-46	21	5	4-37	38	32	12-39	33	48	23-56	27	0	3-34	66	12	11-32
HARVARD COMMUNITY MEM HOSP HARVARD IL 60033	IL-91	207	14	9-21	13	23	7-52	8	38	9-67	7	14	5-64	12	33	8-56	9	67	15-72	5	40	5-73	24	13	12-46
HENROTIN HOSPITAL CHICAGO IL 60610	IL-92 *	319	10	7-17	21	14	6-42	7	29	7-67	9	22	3-54	20	10	9-45	12	25	21-73	11	27	5-54	23	22	10-44
HERRIN HOSP HERRIN IL 62948	IL-93	1111	14	9-17	63	41	17-42	47	38	16-42	26	15	6-38	72	26	13-33	46	50	26-55	46	13	5-29	118	21	14-31
HIGHLAND HOSPITAL INC BELVIDERE IL 61008	IL-94 *	253	15	8-18	9	33	4-56	10	40	13-67	9	44	6-60	14	36	8-51	8	25	12-72	13	31	6-51	31	26	8-37
HIGHLAND PARK HOSPITAL HIGHLAND PARK IL 60035	IL-95	1614	12	9-16	125	32	20-40	63	41	19-42	33	27	10-40	70	11	14-34	62	32	31-57	43	33	12-40	127	20	15-31
HILLSBORO HOSP HILLSBORO IL 62049	IL-96 *	498	12	10-19	21	24	13-52	24	21	14-50	6	0	3-65	33	24	10-39	21	48	23-64	6	33	2-64	65	25	13-34
HINSDALE SANITARIUM HOSP HINSDALE IL 60521	IL-97	2483	11	9-15	195	19	16-33	82	26	19-39	49	20	12-37	121	21	16-32	75	32	27-50	52	25	12-38	177	25	15-29
HOLY CROSS HOSPITAL CHICAGO IL 60629	IL-98 *	3406	14	9-15	224	26	16-32	135	34	19-35	76	22	10-31	238	20	16-28	117	44	29-48	95	27	12-33	287	25	15-27

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
FRANK CUNEO MEMORIAL HOSPI CHICAGO IL 60613	3	0	1-83	6	0	14-82	2	0	0-97	2	0	0-100	21	19	1-28	17	18	3-38	2	0	0-100	18	11	0-31	5	0	0-100
FRANKLIN BLVD COMMUNITY HO CHICAGO IL 60624	1	0	0-100	.	.		.	.		.	.		7	0	0-75	.	.		.	.		12	0	0-41	4	0	0-89
FRANKLIN HOSPITAL BENTON IL 62812	5	20	2-71	5	60	7-77	15	7	1-37	1	0	0-100	81	6	2-13	21	0	0-29	5	0	0-100	65	5	2-14	50	2	0-14
FREEPORT MEMORIAL HOSPITAL FREEPORT IL 61032	13	15	8-57	6	50	9-75	63	10	4-20	12	0	0-96	193	9	3-10	90	7	2-15	14	0	0-98	142	5	2-10	98	2	0-8
GALENA-STRAUSS HOSPITAL GALENA IL 61036	1	0	0-97	.	.		1	0	0-98	.	.		21	10	1-28	3	0	0-98	1	0	0-100	11	0	0-48	6	0	0-89
GALESBURG COTTAGE HOSPITAL GALESBURG IL 61401	24	38	13-55	7	43	14-78	41	5	4-24	3	0	0-100	173	6	3-10	76	3	2-15	12	0	0-99	115	3	2-11	129	2	1-98
GIBSON COMMUNITY HOSPITAL GIBSON CITY IL 60936	7	29	6-68	2	0	2-90	7	0	1-57	.	.		48	6	1-16	17	0	0-38	1	0	0-100	23	0	1-26	11	9	0-81
GLENDALE HEIGHTS COMMUNITY GLENDALE HEIGHTS IL 60137	8	13	7-67	16	50	17-63	12	25	3-47	.	.		21	14	3-34	30	20	2-26	1	0	0-100	23	9	1-26	16	0	0-39
GOOD SAMARITAN HOSPITAL DOWNERS GROVE IL 60515	16	13	6-50	18	33	18-62	62	8	4-21	19	0	0-89	176	3	2-9	62	2	1-16	19	0	0-72	256	6	2-8	101	0	0-8
GOOD SAMARITAN HOSPITAL MOUNT VERNON IL 62864	26	23	17-58	21	29	15-55	43	2	5-26	4	0	0-100	141	8	2-11	72	1	2-16	13	0	0-72	103	5	2-12	142	1	0-6
GOOD SHEPHERD HOSPITAL BARRINGTON IL 60010	7	0	10-74	12	42	17-69	42	2	4-25	10	0	0-99	86	6	2-13	38	3	1-20	5	0	0-68	68	4	2-15	73	3	0-10
GOTTLIEB MEMORIAL HOSPITAL MELROSE PARK IL 60160	11	18	10-64	8	13	12-72	33	12	2-25	3	0	0-99	162	5	3-11	86	2	1-13	13	0	0-83	215	3	2-8	104	0	0-8
GRAHAM HOSPITAL ASSOCIATIO CANTON IL 61520	7	0	2-63	16	19	15-60	28	18	3-28	.	.		140	4	2-10	56	2	2-18	20	5	0-37	108	6	2-11	70	0	0-11
GRANT HOSPITAL CHICAGO IL 60614	20	40	8-50	27	26	22-60	45	4	3-22	19	0	0-97	196	3	3-11	131	10	4-16	10	0	0-71	168	4	3-10	87	0	0-9
HAMILTON MEMORIAL HOSPITAL MCLEANSBORO IL 62859	10	30	9-65	2	0	2-90	5	0	0-71	.	.		40	3	2-20	24	0	2-28	1	0	0-99	48	6	2-17	15	0	0-35
HAMMOND HENRY DISTRICT HOS GENESEO IL 61254	4	25	3-77	2	50	3-91	16	6	2-36	.	.		46	2	1-17	22	5	0-28	4	0	0-100	40	3	1-17	16	0	0-47
HARDIN CO GEN HOSP ROSICLARE IL 62982	.	.		.	.		.	.		1	100	0-100	52	10	1-16	13	0	0-42	1	0	0-100	47	4	1-17	24	4	0-26
HARRISBURG MEDICAL CENTER HARRISBURG IL 62946	12	25	6-56	6	33	7-73	18	6	2-34	1	0	0-100	104	2	1-10	44	0	1-18	7	0	0-99	68	18	2-14	20	0	0-42
HARVARD COMMUNITY MEM HOSP HARVARD IL 60033	5	20	3-72	4	25	7-81	6	0	1-62	.	.		22	5	0-27	10	0	0-54	.	.		23	17	1-26	13	0	0-68
HENROTIN HOSPITAL CHICAGO IL 60610	5	60	10-81	3	33	3-84	10	0	0-49	1	0	0-100	20	10	0-31	12	8	0-47	1	0	0-100	19	0	0-30	32	0	0-23
HERRIN HOSP HERRIN IL 62948	11	55	8-61	8	13	10-70	37	8	2-22	.	.		99	7	2-13	55	11	3-19	4	0	0-99	127	2	2-10	62	0	0-12
HIGHLAND HOSPITAL INC BELVIDERE IL 61008	1	0	0-99	3	0	7-88	10	0	1-47	.	.		28	0	1-22	17	12	0-36	2	0	0-100	23	9	1-25	11	0	0-58
HIGHLAND PARK HOSPITAL HIGHLAND PARK IL 60035	15	13	6-53	9	33	10-67	50	8	3-21	29	0	0-42	145	5	2-11	84	2	1-13	14	0	0-99	97	2	2-12	146	1	0-6
HILLSBORO HOSP HILLSBORO IL 62049	11	18	10-64	5	60	7-77	14	7	2-39	.	.		87	1	3-14	3	0	0-90	4	0	0-100	40	3	1-18	16	0	0-34
HINSDALE SANITARIUM HOSP HINSDALE IL 60521	17	18	8-52	30	43	24-60	93	6	4-18	18	0	0-88	220	3	2-9	82	7	2-15	30	0	0-62	194	5	2-9	216	1	1-5
HOLY CROSS HOSPITAL CHICAGO IL 60629	15	20	10-58	25	28	21-59	84	7	4-19	5	0	0-100	382	6	3-9	193	12	2-11	22	0	0-72	306	4	3-8	187	2	0-5

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HOLY FAMILY HOSP DES PLAINES IL 60016	IL-99	1898	13	10-16	145	17	14-32	77	25	18-39	60	18	11-34	116	20	15-31	98	34	29-50	38	24	8-36	156	27	14-29
HOOPESTON COMMUNITY MEMORI HOOPESTON IL 60942	IL-100*	141	12	8-21	9	0	3-55	7	43	13-76	4	0	5-79	5	40	3-70	5	60	8-78	6	17	1-64	19	5	6-42
HOPEDALE HOSPITAL HOPEDALE IL 61747	IL-101*	163	12	8-20	9	56	3-55	7	14	6-66	1	0	0-99	7	29	4-62	2	50	6-94	.	.		25	24	11-45
HUMANA HOSPITAL HOFFMAN ES HOFFMAN ESTATES IL 60194	IL-102	894	14	9-16	34	21	8-37	36	39	15-44	19	5	9-48	74	26	15-35	37	57	26-58	31	29	6-36	88	20	11-30
HUMANA HOSPITAL OF SPRINGF SPRINGFIELD IL 62703	IL-103*	528	11	9-18	24	17	11-47	21	19	15-53	13	31	7-53	36	22	11-38	12	42	22-73	19	21	9-48	76	17	10-28
HYDE PARK COMMUNITY HOSPIT CHICAGO IL 60637	IL-104	835	12	11-18	42	26	19-49	49	14	19-45	32	13	10-40	39	18	14-41	13	23	18-68	22	32	10-47	72	17	11-31
ILLINI COMMUNITY HOSPITAL PITTSFIELD IL 62363	IL-105	517	16	10-18	16	38	16-61	18	33	14-56	6	17	6-70	30	27	14-45	12	50	23-74	20	20	7-44	69	23	12-33
ILLINI HOSPITAL DISTRICT SILVIS IL 61282	IL-106*	1003	14	9-16	58	33	17-42	30	47	13-45	24	21	9-43	70	30	13-33	30	57	23-58	35	17	6-35	103	22	12-29
ILLINOIS MASONIC MED CTR CHICAGO IL 60657	IL-107*	1845	10	8-15	119	24	19-39	56	27	19-44	33	27	10-39	86	13	15-34	49	31	27-55	42	21	10-37	129	21	13-29
ILLINOIS VALLEY COMMINITY PERU IL 61354	IL-108*	817	13	10-17	46	26	15-43	47	30	19-46	13	8	3-46	51	29	13-36	33	39	23-56	11	0	4-52	73	29	15-36
ILLINOIS VETERANS HOME QUINCY IL 62301	IL-109*	191	28	12-25	4	50	9-84	5	40	6-75	3	67	12-93	6	50	5-68	2	50	5-94	9	67	7-62	54	39	17-42
INGALLS MEMORIAL HOSPITAL HARVEY IL 60426	IL-110	3860	14	10-16	268	32	19-34	144	23	21-37	92	17	11-31	264	28	17-29	120	39	29-48	102	28	16-37	307	25	15-27
IROQUOIS MEMORIAL HOSPITAL WATSEKA IL 60970	IL-111*	647	13	10-18	31	23	9-39	28	32	16-50	21	19	9-46	53	19	12-35	23	43	23-62	16	0	5-46	102	26	15-33
JACKSON PARK HOSPITAL FOUN CHICAGO IL 60649	IL-112*	969	14	9-16	28	46	19-55	38	32	15-43	18	17	6-44	62	21	13-34	26	50	22-59	58	19	11-36	81	23	11-30
JERSEY COMMUNITY HOSPITAL JERSEYVILLE IL 62052	IL-113*	555	11	9-17	15	20	7-50	21	29	14-53	7	29	3-62	44	25	14-40	8	38	11-70	8	0	4-60	101	18	14-32
JOHN AND MARY KIRBY HOSPIT MONTICELLO IL 61856	IL-114*	189	11	8-19	11	9	6-54	4	25	6-81	5	0	1-68	11	9	6-55	5	40	13-84	6	17	3-66	21	33	8-44
JOHN F KENNEDY MEDICAL CEN CHICAGO IL 60634	IL-115	2869	14	9-16	140	23	14-32	134	38	22-39	70	17	9-30	237	19	16-28	107	51	29-49	85	22	9-29	220	20	15-28
KATHERINE SHAW BETHEA HOSP DIXON IL 61021	IL-116*	902	13	9-16	41	22	12-40	30	27	15-48	31	19	6-35	45	11	14-39	35	57	25-57	27	19	7-39	101	19	12-29
KEWANEE PUBLIC HOSPITAL KEWANEE IL 61443	IL-117*	734	13	9-17	27	41	11-45	23	39	14-50	17	18	3-40	58	19	13-35	26	46	23-59	11	0	2-49	114	23	13-30
KISHWAUKEE COMMUNITY HOSPI DE KALB IL 60115	IL-118*	703	9	7-15	55	4	11-35	29	21	14-46	11	9	2-47	29	24	9-39	37	43	21-52	13	8	3-46	51	20	9-32
LA GRANGE MEMORIAL HOSPITA LA GRANGE IL 60525	IL-119*	2376	12	9-15	168	19	15-32	106	25	20-38	54	17	12-37	152	24	15-29	84	43	27-49	44	25	10-37	168	17	14-29
LA HARPE HOSP LA HARPE IL 61450	IL-120	51	14	5-24	1	100	0-98	2	0	2-89	.	.		2	50	1-89	.	.		2	0	1-89	11	0	3-48
LAKE FOREST HOSPITAL LAKE FOREST IL 60045	IL-121	1036	12	9-17	114	29	18-38	44	18	16-43	26	12	7-39	35	26	11-40	15	40	22-69	28	11	6-38	101	17	12-29
LAKESIDE COMMUNITY HOSPITA CHICAGO IL 60616	IL-122*	203	11	6-16	6	83	14-81	3	33	2-82	2	0	1-89	17	18	7-45	1	100	3-100	9	22	5-58	18	17	6-42
LAKEVIEW MEDICAL CENTER DANVILLE IL 61832	IL-123	1192	16	9-16	85	38	16-38	50	40	17-42	36	19	9-37	52	23	13-36	44	52	26-55	32	16	7-37	120	23	11-26
LAWRENCE COUNTY MEMORIAL H LAWRENCEVILLE IL 62439	IL-124*	542	14	10-19	11	45	6-56	39	8	16-44	24	17	7-41	37	27	12-40	12	42	13-63	31	23	10-42	77	25	12-32

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HOLY FAMILY HOSP DES PLAINES IL 60016	12	25	7-58	26	62	21-59	61	11	3-20	2	0	0-100	209	8	2-10	92	7	1-13	23	0	0-58	151	5	2-10	118	2	0-7
HOOPESTON COMMUNITY MEMORI HOOPESTON IL 60942	.	.		1	100	3-99	2	0	0-97	.	.		30	[illegible]	2-24	11	18	0-50	3	0	0-100	2	50	1-89	9	11	0-83
HOPEDALE HOSPITAL HOPEDALE IL 61747	4	25	6-82	3	0	5-87	.	.		.	.		20	0	1-29	7	14	1-57	2	0	0-99	10	10	1-46	14	0	0-69
HUMANA HOSPITAL HOFFMAN ES HOFFMAN ESTATES IL 60194	5	40	7-78	12	42	16-68	27	7	1-26	2	0	0-100	85	8	2-13	48	4	2-19	6	0	0-100	65	0	1-14	54	2	0-14
HUMANA HOSPITAL OF SPRINGF SPRINGFIELD IL 62703	2	50	2-90	5	80	11-82	21	14	2-32	.	.		65	2	2-15	26	0	0-26	[illegible]	0	0-100	19	5	1-29	25	0	0-25
HYDE PARK COMMUNITY HOSPIT CHICAGO IL 60637	9	11	5-62	14	64	21-71	11	0	4-50	3	0	0-100	51	8	2-18	43	7	4-24	4	[illegible]	0-100	74	7	2-13	24	0	0-35
ILLINI COMMUNITY HOSPITAL PITTSFIELD IL 62363	7	43	7-70	5	40	15-86	10	40	3-50	.	.		51	8	2-17	31	16	1-24	3	0	0-100	62	3	1-14	12	0	0-68
ILLINI HOSPITAL DISTRICT SILVIS IL 61282	9	67	11-69	9	22	13-71	22	5	2-29	1	0	0-100	114	2	2-11	25	8	1-26	14	0	0-100	81	10	2-13	70	6	0-10
ILLINOIS MASONIC MED CTR CHICAGO IL 60657	13	23	6-55	11	45	21-75	41	2	2-21	75	0	0-15	148	7	3-11	72	7	3-17	9	0	0-96	229	3	2-9	99	1	0-8
ILLINOIS VALLEY COMMINITY PERU IL 61354	10	50	12-69	3	[illegible]	6-88	19	11	3-35	16	0	0-87	95	4	3-13	41	2	1-19	12	8	0-47	76	4	2-13	55	0	0-12
ILLINOIS VETERANS HOME QUINCY IL 62301	2	0	0-92	5	20	8-78	1	0	0-99	1	0	0-100	[illegible]	0	1-73	7	29	0-60	.	.		15	33	2-38	2	0	0-100
INGALLS MEMORIAL HOSPITAL HARVEY IL 60426	28	32	13-52	54	48	28-57	73	8	5-21	86	0	0-10	362	7	4-10	198	8	3-13	34	0	0-29	362	4	3-8	211	1	1-5
IROQUOIS MEMORIAL HOSPITAL WATSEKA IL 60970	2	0	1-90	7	0	9-71	16	6	1-35	.	.		60	5	2-17	36	6	1-21	7	0	0-92	70	1	2-14	10	[illegible]	0-49
JACKSON PARK HOSPITAL FOUN CHICAGO IL 60649	11	27	5-57	7	43	11-74	25	28	4-32	7	0	0-100	66	9	2-16	38	3	2-21	.	.		89	6	1-11	46	0	0-16
JERSEY COMMUNITY HOSPITAL JERSEYVILLE IL 62052	10	50	6-60	5	40	8-78	12	0	2-43	3	0	0-100	73	5	2-14	31	3	1-23	4	0	0-100	41	0	1-17	24	4	0-36
JOHN AND MARY KIRBY HOSPIT MONTICELLO IL 61856	2	100	5-94	2	0	3-91	1	0	0-99	.	.		29	0	1-22	3	0	0-86	2	0	0-100	15	7	2-37	9	0	0-72
JOHN F KENNEDY MEDICAL CEN CHICAGO IL 60634	17	35	12-58	26	35	21-60	85	5	4-19	47	0	0-33	278	8	3-9	117	5	2-13	19	0	0-98	262	5	2-8	154	1	0-6
KATHERINE SHAW BETHEA HOSP DIXON IL 61021	3	67	2-83	18	33	19-63	39	5	3-24	.	.		83	10	1-12	30	13	1-23	6	0	0-100	60	3	1-14	57	2	0-12
KEWANEE PUBLIC HOSPITAL KEWANEE IL 61443	10	30	11-67	1	0	0-97	16	6	1-35	.	.		97	3	2-13	32	16	2-24	[illegible]	0	0-100	65	2	1-13	28	4	0-31
KISHWAUKEE COMMUNITY HOSPI DE KALB IL 60115	2	0	1-90	6	33	12-79	39	0	2-22	[illegible]	0	0-100	78	4	2-13	55	5	1-16	11	0	0-100	60	0	1-14	45	0	0-16
LA GRANGE MEMORIAL HOSPITA LA GRANGE IL 60525	31	39	13-51	26	38	23-61	71	11	4-19	8	13	0-99	326	6	2-8	91	3	2-15	19	0	0-74	209	4	2-8	155	1	0-6
LA HARPE HOSP LA HARPE IL 61450	.	.		.	.		3	[illegible]	0-89	.	.		6	17	0-68	2	0	0-91	.	.		1	0	0-100	3	0	0-99
LAKE FOREST HOSPITAL LAKE FOREST IL 60045	16	25	8-54	14	21	20-69	41	7	2-21	11	[illegible]	0-97	119	4	2-11	49	0	1-17	9	0	0-100	54	7	2-16	68	0	0-10
LAKESIDE COMMUNITY HOSPITA CHICAGO IL 60616	3	0	2-83	.	.		2	50	0-93	.	.		20	5	1-29	8	25	1-54	.	.		19	0	1-29	28	0	0-46
LAKEVIEW MEDICAL CENTER DANVILLE IL 61832	17	29	10-56	17	59	17-62	34	9	3-25	6	[illegible]	0-100	145	6	2-11	58	7	2-18	[illegible]	0	0-100	78	8	1-12	52	[illegible]	0-13
LAWRENCE COUNTY MEMORIAL H LAWRENCEVILLE IL 62439	4	75	5-80	7	57	10-73	13	31	2-41	.	.		64	5	2-15	19	5	2-32	6	33	0-94	35	6	1-20	16	0	0-36

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LINCOLN WEST MEDICAL CENTE CHICAGO IL 60618	IL-125*	543	13	8-16	17	18	9-51	20	15	11-49	14	21	6-50	32	31	11-41	9	22	12-69	14	14	6-50	58	29	12-34
LITTLE COMPANY OF MARY HOS EVERGREEN PARK IL 60642	IL-126	2923	13	9-15	223	25	16-32	100	28	19-38	68	19	11-32	150	23	16-30	130	27	29-47	70	29	10-33	224	18	13-26
LORETTO HOSP CHICAGO IL 60644	IL-127	701	12	7-14	35	34	11-41	30	37	16-49	18	11	4-41	26	8	9-40	28	68	23-59	12	8	6-53	55	22	10-32
LOUIS A WEISS MEMORIAL HOS CHICAGO IL 60640	IL-128*	2325	13	10-17	154	26	18-36	70	26	20-42	69	16	11-32	128	22	17-32	77	45	28-51	81	14	9-31	216	23	16-30
LUTHERAN HOSPITAL MOLINE IL 61265	IL-129	1705	18	11-18	195	44	23-40	43	40	16-43	46	15	11-38	87	30	15-33	57	26	27-53	40	20	9-37	208	24	13-27
LUTHERN GENERAL HOSPITAL PARK RIDGE IL 60068	IL-130	4174	13	10-16	336	23	17-31	147	33	21-37	134	22	13-31	202	20	18-31	161	37	29-46	54	9	8-32	347	31	18-30
MACNEAL MEMORIAL HOSPITAL BERWYN IL 60402	IL-131	2794	15	10-16	226	22	14-30	140	33	20-36	67	18	11-33	152	18	15-30	166	40	30-47	65	17	9-32	196	27	17-31
MARION MEMORIAL HOSPITAL MARION IL 62959	IL-132	1129	12	9-16	64	22	15-39	36	33	16-46	25	16	9-42	73	29	14-34	30	43	26-61	29	24	10-43	120	20	14-30
MARSHALL BROWNING HOSPITAL DU QUOIN IL 62832	IL-133*	360	17	10-20	12	42	9-58	18	39	15-57	8	13	4-58	19	53	11-50	21	48	21-62	7	29	5-66	66	11	10-30
MARTHA WASHINGTON HOSPITAL CHICAGO IL 60618	IL-134	957	8	9-16	37	24	14-44	34	26	15-45	24	13	4-36	73	10	15-35	29	24	23-58	19	16	4-41	96	14	13-31
MARY THOMPSON HOSPITAL CHICAGO IL 60607	IL-135*	427	14	9-18	30	37	17-51	14	50	15-62	5	40	1-68	34	21	10-38	3	33	10-91	9	0	2-53	33	15	11-40
MASON DISTRICT HOSPITAL HAVANA IL 62644	IL-136*	341	13	9-18	19	26	10-50	9	0	6-59	16	19	6-46	22	27	9-44	10	60	15-70	8	25	4-59	25	12	11-45
MASSAC MEMORIAL HOSPITAL METROPOLIS IL 62960	IL-137*	581	15	10-19	21	48	11-50	16	19	13-56	19	16	5-41	43	16	12-38	32	25	23-57	18	22	6-44	84	26	12-31
MCDONOUGH CO DISTRICT HOSP MACOMB IL 61455	IL-138	1371	11	8-15	76	29	18-40	48	44	17-44	18	17	4-41	64	22	15-37	38	37	24-55	21	14	5-40	137	14	13-28
MEMORIAL HOSPITAL BELLEVILLE IL 62223	IL-139	2887	11	9-15	174	22	17-35	106	25	21-40	48	19	11-37	182	27	17-31	95	34	29-50	54	22	9-34	197	18	14-27
MEMORIAL HOSPITAL CARBONDALE IL 62901	IL-140	1076	12	8-16	88	28	15-36	26	19	14-49	19	37	8-47	41	12	11-37	30	43	20-54	27	22	7-39	106	25	12-29
MEMORIAL HOSPITAL CARTHAGE IL 62321	IL-141	373	13	9-18	18	22	9-48	8	38	7-64	10	10	3-51	19	32	10-48	21	43	18-58	5	0	3-70	74	15	11-31
MEMORIAL HOSPITAL CHESTER IL 62233	IL-142*	522	14	8-17	36	31	12-42	24	29	14-50	14	21	7-51	30	40	11-41	17	53	19-63	3	33	1-81	39	18	12-39
MEMORIAL HOSPITAL FOR MCHE WOODSTOCK IL 60098	IL-143*	859	12	9-16	58	29	12-35	35	23	15-44	16	25	9-51	53	26	14-37	36	47	24-56	32	3	3-31	72	22	12-32
MEMORIAL MEDICAL CENTER SPRINGFIELD IL 62781	IL-144	4326	10	8-14	346	22	19-34	87	26	19-39	85	16	10-29	167	30	18-33	88	38	26-48	48	15	7-32	275	16	15-28
MENDOTA COMM HOSP MENDOTA IL 61342	IL-145*	475	11	9-17	34	32	13-43	19	21	9-47	6	33	2-64	29	24	9-39	21	38	25-66	11	27	6-55	39	13	9-36
MENNONITE HOSP BLOOMINGTON IL 61701	IL-146*	1228	11	8-15	100	39	22-43	33	33	16-47	29	7	5-33	46	17	14-39	40	40	28-58	32	16	7-37	73	16	12-32
MERCER COUNTY HOSPITAL ALEDO IL 61231	IL-147*	328	9	7-17	9	11	7-62	5	20	6-74	4	0	1-75	30	20	11-42	13	38	20-69	8	0	2-57	24	13	8-41
MERCY CENTER FOR HEALTH CA AURORA IL 60506	IL-148*	1364	11	7-13	101	22	13-33	47	28	18-45	27	11	9-41	69	23	11-31	30	50	22-56	27	22	7-40	81	26	9-28
MERCY HOSP MED CENTER CHICAGO IL 60616	IL-149	2822	13	9-15	177	22	18-35	80	29	18-38	76	29	11-32	170	18	15-28	83	33	29-51	88	23	15-37	213	19	13-27
MERCY HOSPITAL URBANA IL 61801	IL-150	1450	11	8-15	130	28	20-40	31	23	15-46	24	38	6-39	61	21	13-34	50	46	25-52	16	6	3-41	88	30	13-32

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LINCOLN WEST MEDICAL CENTE CHICAGO IL 60618	5	40	6-77	7	43	10-73	9	22	1-50	2	0	0-100	65	8	2-15	30	10	2-25	5	0	1-68	34	3	1-19	69	3	0-10
LITTLE COMPANY OF MARY HOS EVERGREEN PARK IL 60642	27	7	8-46	25	40	19-57	72	19	3-18	19	0	0-87	315	8	3-9	124	4	2-12	23	0	0-59	167	4	2-9	235	2	1-5
LORETTO HOSP CHICAGO IL 60644	7	0	4-65	1	0	2-98	9	0	0-50	.	.		44	7	2-19	27	0	0-26	1	0	0-100	50	8	1-15	35	9	0-20
LOUIS A WEISS MEMORIAL HOS CHICAGO IL 60640	19	16	7-49	51	45	26-56	46	15	5-26	12	0	0-92	233	7	4-11	143	4	3-14	16	0	0-96	261	4	3-9	97	1	0-8
LUTHERAN HOSPITAL MOLINE IL 61265	11	45	15-71	36	33	21-54	52	8	3-20	6	0	0-100	151	7	2-11	58	17	2-18	12	0	0-100	108	4	2-10	114	3	0-7
LUTHERN GENERAL HOSPITAL PARK RIDGE IL 60068	34	26	10-45	49	45	26-57	125	6	5-17	73	0	0-16	321	5	3-9	205	7	3-13	19	0	0-39	342	5	3-8	275	2	1-5
MACNEAL MEMORIAL HOSPITAL BERWYN IL 60402	27	19	11-50	36	22	21-54	102	10	4-18	22	0	0-88	268	7	2-9	147	10	2-12	20	0	0-89	202	6	2-9	171	3	1-6
MARION MEMORIAL HOSPITAL MARION IL 62959	4	50	4-79	6	33	11-78	40	10	4-26	41	0	0-42	147	4	3-11	40	10	3-23	10	0	0-80	112	4	2-11	78	1	0-9
MARSHALL BROWNING HOSPITAL DU QUOIN IL 62832	4	75	5-80	3	0	2-82	9	22	1-50	.	.		60	5	2-15	12	8	2-44	4	0	0-100	39	8	1-18	13	0	0-53
MARTHA WASHINGTON HOSPITAL CHICAGO IL 60618	5	0	1-71	17	18	18-64	13	0	1-40	1	0	0-100	104	6	2-12	40	10	2-21	5	0	0-100	83	2	2-13	76	3	0-10
MARY THOMPSON HOSPITAL CHICAGO IL 60607	8	63	7-67	7	43	12-75	1	0	0-99	2	0	0-100	42	2	1-18	20	10	1-31	2	0	0-100	46	2	1-16	18	0	0-48
MASON DISTRICT HOSPITAL HAVANA IL 62644	5	40	4-73	7	14	13-76	15	20	2-38	.	.		28	11	1-23	19	0	1-31	3	0	0-100	24	13	1-26	16	0	0-44
MASSAC MEMORIAL HOSPITAL METROPOLIS IL 62960	8	13	12-73	9	67	15-73	7	0	2-58	1	0	0-100	67	4	2-15	6	0	0-63	4	0	0-100	81	2	2-12	13	0	0-47
MCDONOUGH CO DISTRICT HOSP MACOMB IL 61455	12	17	4-54	14	36	17-66	56	11	3-20	53	2	0-25	151	9	3-11	50	4	1-17	13	0	0-98	77	5	2-14	141	2	0-6
MEMORIAL HOSPITAL BELLEVILLE IL 62223	22	36	17-60	44	39	21-52	63	3	4-21	5	0	0-100	250	5	3-9	130	8	3-14	17	0	0-55	301	2	3-8	252	1	1-5
MEMORIAL HOSPITAL CARBONDALE IL 62901	11	0	6-59	11	27	17-71	42	10	2-22	9	0	0-100	113	4	2-12	60	5	1-16	18	0	0-94	70	7	2-14	77	4	1-10
MEMORIAL HOSPITAL CARTHAGE IL 62321	1	0	0-97	5	20	8-79	9	0	1-50	.	.		42	7	1-18	7	14	0-65	2	0	0-100	17	12	1-32	26	8	0-26
MEMORIAL HOSPITAL CHESTER IL 62233	2	0	3-92	4	50	8-83	17	12	2-36	.	.		65	3	2-14	29	7	1-24	3	33	0-99	46	13	1-17	25	0	0-27
MEMORIAL HOSPITAL FOR MCHE WOODSTOCK IL 60098	8	25	6-65	12	42	14-66	29	7	2-26	3	0	0-100	91	3	1-11	36	3	1-21	7	0	0-100	55	9	1-14	51	6	0-14
MEMORIAL MEDICAL CENTER SPRINGFIELD IL 62781	63	21	12-42	29	28	19-56	118	8	4-16	29	0	0-46	335	5	3-9	178	3	1-10	48	0	0-34	408	5	3-8	332	2	0-4
MENDOTA COMM HOSP MENDOTA IL 61342	6	17	3-68	7	14	18-82	21	5	2-31	.	.		51	4	2-17	13	0	0-41	6	0	0-100	41	0	1-17	19	0	0-51
MENNONITE HOSP BLOOMINGTON IL 61701	5	0	5-75	4	25	13-89	32	6	2-25	118	0	0-9	148	7	3-11	49	2	1-17	11	0	0-98	70	6	1-13	111	1	0-7
MERCER COUNTY HOSPITAL ALEDO IL 61231	5	0	4-73	3	33	6-87	16	13	2-37	1	100	0-100	48	6	2-18	18	0	0-34	5	0	0-100	40	5	1-18	22	9	0-37
MERCY CENTER FOR HEALTH CA AURORA IL 60506	9	56	7-65	12	75	11-61	45	11	2-21	1	0	0-100	102	6	2-11	56	5	1-16	13	0	0-69	77	4	1-12	119	1	0-7
MERCY HOSP MED CENTER CHICAGO IL 60616	18	17	12-58	28	57	22-60	37	14	3-25	14	0	0-96	201	7	2-10	119	12	4-15	12	0	0-100	252	10	2-8	140	3	0-6
MERCY HOSPITAL URBANA IL 61801	7	0	4-65	13	31	17-67	36	3	3-25	47	0	0-25	123	4	2-11	72	1	1-14	19	0	0-52	135	5	3-12	87	1	0-9

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name, Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
METHODIST HOSPITAL CHICAGO CHICAGO IL 60640	IL-151	1227	16	11-18	54	41	16-42	27	41	15-49	51	22	10-35	52	29	15-39	21	38	23-64	39	18	7-35	136	28	17-34
METHODIST MEDICAL CENTER O PEORIA IL 61636	IL-152*	4031	11	8-15	415	28	20-34	88	32	20-40	90	8	9-28	165	24	17-31	123	37	28-47	50	16	8-33	297	19	15-27
MICHAEL REESE HOSP MEDICAL CHICAGO IL 60616	IL-153	2897	12	9-16	284	26	19-34	126	27	19-36	55	25	10-34	147	20	16-30	85	26	27-49	85	22	10-32	170	25	16-31
MOLINE PUBLIC HOSPITAL MOLINE IL 61265	IL-154*	1098	12	8-16	91	18	11-31	43	35	17-44	20	15	4-38	63	25	15-37	46	37	26-54	22	18	5-40	70	26	14-35
MORRIS HOSP MORRIS IL 60450	IL-155	863	11	10-17	53	32	15-41	42	26	15-43	26	31	9-42	76	16	13-33	23	43	24-63	20	5	3-38	97	13	12-29
MORRISON COMMUNITY HOSPITA MORRISON IL 61270	IL-156	183	15	8-20	14	36	8-52	10	30	10-63	5	80	3-70	8	50	6-62	2	50	4-92	10	0	4-55	11	36	8-57
MT SINAI HOSP MEDICAL CENT CHICAGO IL 60608	IL-157	1351	14	8-15	108	30	17-37	46	26	15-41	36	11	6-33	80	11	12-30	21	57	18-58	46	9	7-32	114	28	12-28
NORTHERN ILLINOIS MEDICAL MCHENRY IL 60050	IL-158*	1320	13	10-17	86	19	15-36	43	35	17-44	34	18	10-39	93	22	14-32	59	34	29-55	32	9	10-41	156	25	15-30
NORTHWEST COMM HOSP ARLINGTON HEIGHTS IL 60005	IL-159	3301	11	9-16	294	24	20-35	134	34	22-39	88	18	12-31	165	23	18-32	98	43	30-51	82	17	10-31	226	22	15-28
NORTHWESTERN MEMORIAL HOSP CHICAGO IL 60611	IL-160	4272	9	8-14	446	22	18-31	111	19	19-37	90	8	9-28	125	26	16-32	124	34	31-50	68	22	12-36	217	17	14-28
NORWEGIAN-AMERICAN HOSP CHICAGO IL 60622	IL-161	328	12	7-16	13	0	11-59	10	10	8-60	11	18	3-49	15	20	12-56	4	25	8-82	6	17	2-64	49	31	11-35
OAK FOREST HOSPITAL OAK FOREST IL 60452	IL-162	676	37	13-21	9	11	6-60	5	60	5-73	28	43	8-40	35	57	14-43	14	86	18-66	20	70	7-44	137	59	20-37
OAK PARK HOSP OAK PARK IL 60304	IL-163*	2157	16	10-17	149	30	16-34	82	38	20-40	65	28	11-33	165	30	17-32	73	30	25-49	51	24	10-35	205	21	16-30
OLIVER C ANDERSON HOSPITAL MARYVILLE IL 62062	IL-164*	1083	14	10-17	51	24	11-36	43	53	17-45	29	17	6-36	57	23	14-36	62	44	28-54	15	20	6-48	112	23	14-31
PALOS COMMUNITY HOSPITAL PALOS HEIGHTS IL 60463	IL-165*	2506	13	10-16	203	30	18-35	72	33	18-40	56	20	10-34	137	17	16-31	79	51	28-50	70	21	13-37	258	20	15-27
PANA COMMUNITY HOSPITAL PANA IL 62557	IL-166*	431	15	9-18	19	26	11-51	15	33	14-59	6	33	1-63	42	26	13-38	17	53	22-67	10	20	8-61	39	21	9-35
PARIS COMMUNITY HOSPITAL PARIS IL 61944	IL-167	634	15	9-17	37	30	11-41	32	28	16-47	17	24	5-44	71	18	15-35	17	71	19-63	20	15	4-39	60	18	10-31
PASSAVANT MEMORIAL AREA HO JACKSONVILLE IL 62650	IL-168*	1754	13	8-15	86	23	15-37	45	33	16-43	53	32	11-35	94	21	15-32	59	63	28-54	31	42	9-40	158	20	14-29
PAXTON COMM HOSP PAXTON IL 60957	IL-169*	147	16	10-23	11	27	6-55	10	50	8-60	3	0	1-81	14	21	7-49	8	38	13-73	5	0	2-69	26	23	12-46
PEARCE HOSPITAL FOUNDATION ELDORADO IL 62930	IL-170*	342	11	7-16	3	33	5-86	10	40	12-66	4	0	0-76	17	24	11-53	8	75	16-76	4	25	3-76	25	20	8-41
PEKIN MEMORIAL HOSPITAL PEKIN IL 61554	IL-171*	1305	14	9-16	89	26	13-34	48	31	18-44	36	11	8-36	82	30	16-36	44	57	26-55	27	15	5-37	138	20	13-28
PERRY MEMORIAL HOSPITAL PRINCETON IL 61356	IL-172	822	13	9-16	61	26	13-37	22	36	15-53	25	16	5-36	56	27	14-36	39	41	25-55	22	5	5-39	70	20	12-32
PINCKNEYVILLE COMMUNITY HO PINCKNEYVILLE IL 62274	IL-173*	368	12	9-19	13	46	15-64	13	38	12-59	5	0	3-70	28	29	10-42	16	50	24-70	6	33	3-66	33	12	12-42
PROCTOR COMMUNITY HOSPITAL PEORIA IL 61614	IL-174*	1865	11	8-15	125	28	18-37	53	36	19-44	39	23	7-33	105	22	16-33	69	36	25-49	41	7	6-33	177	20	12-26
PROVIDENT HOSPITAL TRAININ CHICAGO IL 60615	IL-175*	582	18	10-18	40	30	14-43	36	58	15-45	17	18	6-44	69	25	13-33	11	64	17-70	28	25	9-41	49	18	9-32
PUBILIC HOSPITAL OF THE TO SALEM IL 62881	IL-176	437	11	9-17	18	28	12-53	13	23	13-61	13	8	2-44	31	29	10-40	15	73	21-67	10	10	4-55	45	13	10-34

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
METHODIST HOSPITAL CHICAGO CHICAGO IL 60640	8	38	5-64	57	44	29-58	20	10	1-31	5	0	0-100	108	3	3-13	68	6	3-18	10	10	0-74	74	5	2-13	54	2	0-13
METHODIST MEDICAL CENTER O PEORIA IL 61636	21	38	11-53	20	20	17-59	93	14	4-17	74	3	0-14	337	2	3-8	180	3	2-11	34	0	0-59	419	5	3-7	257	0	0-4
MICHAEL REESE HOSP MEDICAL CHICAGO IL 60616	36	19	8-43	12	67	16-68	42	5	3-23	94	1	0-12	187	3	3-11	160	10	3-13	14	0	0-91	230	7	3-9	183	1	0-6
MOLINE PUBLIC HOSPITAL MOLINE IL 61265	2	50	2-90	13	38	21-72	32	6	3-26	5	20	0-100	129	5	2-10	46	4	0-19	8	0	0-100	80	5	2-13	78	0	1-10
MORRIS HOSP MORRIS IL 60450	8	25	10-71	14	36	16-65	24	17	2-30	4	0	0-100	112	3	2-11	39	5	2-22	8	0	0-100	88	0	2-12	46	0	0-15
MORRISON COMMUNITY HOSPITA MORRISON IL 61270	1	100	0-97	1	100	1-97	6	0	1-62	.	.		25	8	1-26	10	0	0-63	3	0	0-100	12	0	0-42	12	8	0-53
MT SINAI HOSP MEDICAL CENT CHICAGO IL 60608	13	38	6-55	35	37	19-53	20	5	2-32	3	0	0-98	94	9	2-13	54	4	1-16	2	0	0-100	94	6	1-10	33	0	0-32
NORTHERN ILLINOIS MEDICAL MCHENRY IL 60050	7	43	7-69	25	36	17-54	42	10	5-26	5	0	0-100	105	4	2-11	58	7	1-16	13	0	0-95	110	6	2-10	109	2	1-8
NORTHWEST COMM HOSP ARLINGTON HEIGHTS IL 60005	21	29	11-54	30	33	21-57	105	16	5-18	25	0	0-44	361	3	3-9	154	6	1-11	16	0	0-99	255	2	2-8	289	2	0-4
NORTHWESTERN MEMORIAL HOSP CHICAGO IL 60611	45	7	5-37	12	50	16-68	83	11	3-17	162	1	0-5	319	3	3-9	151	3	2-12	35	0	0-64	386	6	3-8	331	1	0-4
NORWEGIAN-AMERICAN HOSP CHICAGO IL 60622	3	0	0-85	8	63	8-67	5	20	1-68	2	0	0-100	40	5	1-18	25	20	1-27	4	0	0-100	23	0	1-25	17	6	0-58
OAK FOREST HOSPITAL OAK FOREST IL 60452	4	75	8-84	62	52	26-54	2	0	0-91	13	0	0-85	14	21	1-38	32	31	2-24	.	.		4	0	0-74	38	0	0-20
OAK PARK HOSP OAK PARK IL 60304	17	35	11-57	22	41	20-61	57	9	4-22	10	0	0-98	246	10	3-10	134	7	3-14	12	0	0-99	181	3	2-9	123	2	0-7
OLIVER C ANDERSON HOSPITAL MARYVILLE IL 62062	10	20	8-63	12	33	16-68	41	7	2-22	5	0	0-100	122	5	2-12	31	13	2-25	9	0	0-100	79	5	2-13	66	0	0-11
PALOS COMMUNITY HOSPITAL PALOS HEIGHTS IL 60463	10	40	11-67	33	27	24-59	65	6	5-22	7	0	0-100	252	2	3-10	124	6	2-12	29	0	0-38	143	6	2-10	197	4	0-5
PANA COMMUNITY HOSPITAL PANA IL 62557	5	40	4-74	8	38	16-76	9	11	1-50	.	.		53	6	2-16	17	6	0-34	2	0	0-100	49	0	1-16	20	5	0-37
PARIS COMMUNITY HOSPITAL PARIS IL 61944	2	0	2-91	4	0	5-79	27	15	2-27	.	.		80	6	2-13	38	5	1-20	8	0	0-90	37	5	1-20	22	0	0-37
PASSAVANT MEMORIAL AREA HO JACKSONVILLE IL 62650	14	14	7-55	14	21	12-59	47	6	2-20	14	0	0-83	186	5	2-10	95	13	2-14	18	0	0-38	149	5	2-10	107	0	0-8
PAXTON COMM HOSP PAXTON IL 60957	.	.		.	.		.	.		.	.		14	0	0-39	4	0	0-100	4	0	0-100	5	0	0-81	7	0	0-90
PEARCE HOSPITAL FOUNDATION ELDORADO IL 62930	9	11	2-58	6	17	9-75	8	0	2-55	.	.		35	3	1-19	21	5	3-32	1	0	0-100	28	4	1-23	27	0	0-37
PEKIN MEMORIAL HOSPITAL PEKIN IL 61554	12	67	13-66	8	25	9-69	39	21	3-24	19	0	0-81	149	4	2-10	45	2	2-19	12	0	0-94	88	6	2-12	62	2	0-12
PERRY MEMORIAL HOSPITAL PRINCETON IL 61356	4	25	2-76	8	38	12-73	31	6	2-24	.	.		111	5	2-11	51	6	1-17	10	0	0-99	60	2	1-14	55	4	0-12
PINCKNEYVILLE COMMUNITY HO PINCKNEYVILLE IL 62274	4	25	5-80	2	50	5-93	2	0	0-91	.	.		35	0	2-21	17	0	1-34	3	0	0-100	53	8	1-15	20	0	0-31
PROCTOR COMMUNITY HOSPITAL PEORIA IL 61614	10	40	11-67	15	20	15-62	72	8	4-20	32	0	0-47	260	3	3-10	90	7	1-13	19	0	0-79	132	4	2-9	110	3	0-7
PROVIDENT HOSPITAL TRAININ CHICAGO IL 60615	7	14	7-69	10	30	11-66	12	25	3-46	.	.		29	7	1-23	26	0	1-26	2	0	0-100	47	9	1-16	21	5	0-42
PUBILIC HOSPITAL OF THE TO SALEM IL 62881	3	67	4-85	3	67	6-87	3	0	0-81	2	0	0-100	67	1	2-14	15	13	1-37	2	0	0-100	51	2	2-17	8	0	0-77

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	Comment/ Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RAVENSWOOD HOSP MED CENTER CHICAGO IL 60640	IL-177	1709	12	10-16	83	18	20-43	57	28	19-44	41	17	9-35	92	17	14-32	53	53	26-53	54	17	13-39	171	24	16-30
RESURRECTION HOSPITAL CHICAGO IL 60631	IL-178	4542	13	10-16	434	25	17-31	205	25	21-35	142	19	10-26	333	23	18-29	173	40	30-47	94	14	9-29	365	22	15-27
RICHLAND MEMORIAL HOSPITAL OLNEY IL 62450	IL-179	1142	12	10-17	48	23	12-39	50	28	17-42	24	8	8-42	74	22	16-37	54	41	28-55	34	9	6-34	128	16	15-31
RIVERSIDE MEDICAL CENTER KANKAKEE IL 60901	IL-180	1641	11	8-15	88	23	16-38	62	27	17-40	47	19	9-34	74	30	14-34	36	47	26-59	31	29	13-45	115	27	15-32
ROCHELLE COMMUNITY HOSPITA ROCHELLE IL 61068	IL-181	284	15	10-20	16	25	13-58	14	43	12-58	6	0	2-63	15	33	8-50	20	40	21-62	13	31	6-51	19	21	9-46
ROCKFORD MEMORIAL HOSPITAL ROCKFORD IL 61103	IL-182	3126	12	9-15	241	28	17-33	79	32	19-39	65	15	11-34	146	23	16-30	127	43	29-48	46	9	12-39	222	17	14-27
ROSELAND COMMUNITY HOSPITA CHICAGO IL 60628	IL-183	635	16	8-16	19	42	13-54	35	34	13-43	10	20	3-52	44	30	11-35	30	70	23-57	29	17	6-37	41	10	8-33
RUSH NORTH SHORE MEDICAL C SKOKIE IL 60076	IL-184	1479	14	10-17	86	28	16-38	45	33	19-46	29	7	6-36	98	23	16-34	80	51	30-53	35	14	8-37	116	23	17-34
RUSH-PRESBYTERIAN-ST LUKES CHICAGO IL 60612	IL-185	4794	8	7-13	416	19	17-31	72	25	18-40	92	14	12-32	155	17	17-32	120	38	30-49	58	17	10-34	227	21	16-29
SANDWICH COMMUNITY HOSP SANDWICH IL 60548	IL-186*	414	13	8-17	23	22	10-47	15	20	12-57	23	17	7-41	18	28	8-45	14	43	18-66	18	11	5-44	39	18	10-36
SARAH BUSH LINCOLN HEALTH MATTOON IL 61938	IL-187	1744	11	8-15	102	25	14-33	72	28	20-42	47	15	8-32	101	21	15-33	65	35	28-53	29	3	6-37	148	16	12-27
SARAH D CULBERTSON MEMORIA RUSHVILLE IL 62681	IL-188*	480	16	9-18	14	64	17-65	26	23	14-49	6	0	1-63	37	38	11-39	13	54	21-70	14	36	6-49	53	19	13-37
SAUNDERS HOSPITAL AVON IL 61415	IL-189*	64	23	12-33	.	.		2	0	2-90	.	.		4	25	6-81	2	100	8-96	1	0	0-98	11	36	10-61
SAVANNA CITY HOSPITAL SAVANNA IL 61074	IL-190	120	23	11-26	5	20	6-75	4	50	6-80	1	100	1-97	16	44	11-53	5	40	9-78	2	0	1-89	19	37	8-46
SHELBY MEMORIAL HOSPITAL SHELBYVILLE IL 62565	IL-191	490	10	11-20	11	73	14-66	24	13	19-57	13	15	6-51	44	7	13-39	10	50	21-77	17	6	7-48	72	15	16-37
SHERMAN HOSPITAL ELGIN IL 60120	IL-192	2267	12	8-15	132	25	16-34	87	30	19-40	59	17	9-31	130	26	14-29	74	47	26-50	41	37	10-38	158	12	12-27
SILVER CROSS HOSP JOLIET IL 60432	IL-193	1927	13	9-16	101	35	18-39	66	29	18-41	48	17	9-34	134	21	16-31	62	37	26-51	51	25	10-36	186	25	14-29
SOUTH CHICAGO COMM HOSP CHICAGO IL 60617	IL-194	1910	12	9-16	95	29	16-37	80	34	20-41	75	13	10-30	169	20	15-29	89	42	30-52	42	17	9-37	146	16	11-26
SOUTH SHORE HOSPITAL CHICAGO IL 60617	IL-195*	603	11	9-16	39	31	14-43	21	38	12-49	7	14	1-58	65	14	12-33	17	35	19-63	19	5	5-42	48	21	11-35
SOUTH SUBURBAN HOSPITAL HAZEL CREST IL 60429	IL-196	1669	12	9-16	105	22	17-38	48	29	18-44	33	18	8-37	103	19	15-32	70	41	27-51	40	23	10-39	154	21	13-28
SOUTHERN MEDICAL CENTER CAIRO IL 62914	IL-197*	105	10	6-19	4	50	3-76	2	100	3-91	3	33	1-81	5	20	3-70	1	0	1-97	14	0	3-44	14	21	5-47
SPARTA COMMUNITY HOSP DIST SPARTA IL 62286	IL-198*	334	12	10-20	10	50	12-67	21	29	15-54	7	0	2-59	16	19	8-48	17	35	19-63	12	8	9-58	38	16	12-39
ST ANNES HOSPITAL WEST INC NORTHLAKE IL 60164	IL-199	274	9	5-14	24	21	8-42	5	40	5-73	8	0	3-58	12	25	7-54	4	50	6-80	8	0	1-56	17	24	5-43
ST ANNS HOSP OF CHICAGO IN CHICAGO IL 60651	IL-200	801	14	8-15	42	36	16-45	26	42	16-50	16	31	5-44	61	26	13-34	31	42	22-56	24	21	5-39	44	18	8-32
ST ANTHONY HOSPITAL ROCKFORD IL 61108	IL-201	1961	12	9-15	137	24	17-36	60	33	16-39	41	17	9-35	104	20	16-33	92	35	29-50	23	22	5-39	132	17	14-30
ST ANTHONYS HOSPITAL ALTON IL 62002	IL-202	1182	15	10-17	71	32	16-39	48	33	17-43	23	9	7-41	66	23	15-36	45	40	23-52	19	26	13-54	124	30	16-33

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
Name/ Location	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RAVENSWOOD HOSP MED CENTER CHICAGO IL 60640	16	38	8-53	16	31	21-68	39	5	2-22	8	0	0-96	146	8	3-12	68	1	2-15	8	13	0-58	98	5	2-12	72	3	0-10
RESURRECTION HOSPITAL CHICAGO IL 60631	25	28	10-49	31	42	24-59	109	6	3-15	87	0	0-12	513	3	3-8	169	3	2-11	33	0	0-44	314	6	3-8	303	2	1-5
RICHLAND MEMORIAL HOSPITAL OLNEY IL 62450	12	42	12-65	3	100	10-91	34	9	3-26	7	0	0-100	110	5	2-11	74	4	2-16	12	0	0-100	82	6	2-14	53	4	1-13
RIVERSIDE MEDICAL CENTER KANKAKEE IL 60901	11	36	7-60	9	56	14-71	24	4	2-29	[illegible]	0	0-99	164	4	2-9	82	6	2-14	12	0	0-100	132	3	2-10	103	1	0-8
ROCHELLE COMMUNITY HOSPITA ROCHELLE IL 61068	5	20	4-74	2	100	3-91	5	0	2-68	.	.		41	0	1-19	11	0	2-45	5	0	0-99	24	8	1-25	7	14	0-88
ROCKFORD MEMORIAL HOSPITAL ROCKFORD IL 61103	29	38	12-50	27	33	21-59	103	4	4-16	27	0	0-69	259	5	3-10	97	3	2-13	26	4	0-76	275	8	3-8	305	1	1-5
ROSELAND COMMUNITY HOSPITA CHICAGO IL 60628	4	25	1-76	8	63	13-73	17	0	1-34	.	.		48	8	2-17	23	9	2-29	1	0	0-100	73	8	1-12	25	8	0-29
RUSH NORTH SHORE MEDICAL C SKOKIE IL 60076	10	50	7-62	37	41	24-57	50	8	3-21	16	0	0-96	101	7	2-12	88	6	3-16	4	0	0-100	120	5	2-11	145	1	0-6
RUSH-PRESBYTERIAN-ST LUKES CHICAGO IL 60612	66	9	7-37	22	45	22-64	67	1	3-17	153	1	0-6	316	3	3-8	191	4	2-11	40	0	0-40	526	5	3-7	356	1	1-4
SANDWICH COMMUNITY HOSP SANDWICH IL 60548	2	0	3-91	1	100	1-97	12	17	2-43	1	0	0-100	50	6	2-17	16	6	0-42	7	0	0-77	27	11	1-23	12	0	0-72
SARAH BUSH LINCOLN HEALTH MATTOON IL 61938	14	21	6-53	20	30	15-56	83	[illegible]	4-19	4	25	0-97	214	7	3-10	86	3	1-13	14	0	0-98	114	3	2-11	161	1	0-6
SARAH D CULBERTSON MEMORIA RUSHVILLE IL 62681	4	75	7-83	4	50	8-83	2	0	0-96	.	.		37	0	1-19	14	7	1-38	.	.		46	0	1-16	23	0	0-32
SAUNDERS HOSPITAL AVON IL 61415	5	0	7-78	1	100	3-99	.	.		.	.		4	0	1-74	3	33	3-82	.	.		6	0	1-62	1	0	0-100
SAVANNA CITY HOSPITAL SAVANNA IL 61074	5	80	9-80	.	.		6	0	3-64	.	.		2	0	0-100	4	0	1-74	.	.		8	13	0-54	6	0	0-97
SHELBY MEMORIAL HOSPITAL SHELBYVILLE IL 62565	[illegible]	38	10-71	5	40	15-86	6	17	1-62	.	.		41	0	1-19	7	14	1-58	1	0	0-100	54	7	2-16	20	0	0-36
SHERMAN HOSPITAL ELGIN IL 60120	22	27	15-58	29	21	20-56	57	11	4-21	11	0	0-99	206	4	3-10	70	3	1-14	19	0	0-97	283	6	3-9	202	1	0-5
SILVER CROSS HOSP JOLIET IL 60432	20	55	14-58	13	38	14-64	52	[illegible]	3-21	12	0	0-88	201	3	3-11	78	8	2-15	13	0	0-99	192	3	3-9	103	3	0-8
SOUTH CHICAGO COMM HOSP CHICAGO IL 60617	10	20	5-59	20	40	25-68	27	0	2-26	9	0	0-99	183	5	3-10	66	2	1-15	9	0	0-100	213	2	3-9	107	1	0-7
SOUTH SHORE HOSPITAL CHICAGO IL 60617	11	27	5-56	7	43	15-78	12	17	1-43	.	.		80	3	1-12	18	6	0-33	9	0	0-100	57	0	1-15	26	4	0-26
SOUTH SUBURBAN HOSPITAL HAZEL CREST IL 60429	12	25	3-52	23	43	21-61	31	13	3-27	9	0	0-90	190	5	2-10	80	5	3-17	18	0	0-64	141	4	2-10	110	0	0-8
SOUTHERN MEDICAL CENTER CAIRO IL 62914	1	0	0-97	.	.		.	.		.	.		6	0	0-73	2	0	0-100	.	.		14	0	0-38	1	0	0-100
SPARTA COMMUNITY HOSP DIST SPARTA IL 62286	5	20	7-78	2	50	5-94	6	0	1-62	.	.		53	6	1-15	[illegible]	0	0-65	3	0	0-100	48	8	1-17	11	0	0-53
ST ANNES HOSPITAL WEST INC NORTHLAKE IL 60164	3	0	3-84	1	0	0-97	2	0	0-90	8	0	0-100	37	8	1-20	13	[illegible]	0-47	2	0	0-100	17	6	0-32	54	0	0-22
ST ANNS HOSP OF CHICAGO IN CHICAGO IL 60651	5	60	4-74	7	14	9-71	19	0	2-32	4	0	0-100	55	15	2-16	16	6	0-35	6	0	0-98	58	7	1-14	30	13	0-22
ST ANTHONY HOSPITAL ROCKFORD IL 61108	8	38	6-65	28	29	20-56	49	18	3-20	14	0	0-99	163	5	2-10	110	7	2-13	13	8	0-80	286	[illegible]	3-8	138	0	0-6
ST ANTHONYS HOSPITAL ALTON IL 62002	11	45	13-68	17	47	20-66	25	12	4-33	3	0	0-100	101	7	3-14	71	3	2-15	7	0	0-100	91	7	2-12	68	0	0-11

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST ANTHONYS HOSPITAL CHICAGO IL 60623	IL-203*	699	15	9-17	50	32	13-39	39	18	14-42	6	0	3-66	47	26	12-36	30	53	22-56	44	18	7-33	55	27	12-35
ST ANTHONYS MEMORIAL HOSPI EFFINGHAM IL 62401	IL-204	1369	14	9-16	81	25	15-37	55	35	20-45	32	22	7-36	67	30	14-35	43	44	24-53	34	24	11-42	184	27	14-28
ST BERNARD HOSPITAL CHICAGO IL 60621	IL-205*	852	14	9-16	41	24	13-42	40	33	15-42	26	23	6-37	83	19	12-30	40	40	24-54	42	14	7-34	79	14	10-28
ST CLEMENT HOSPITAL RED BUD IL 62278	IL-206*	696	12	10-18	53	36	16-42	18	33	16-58	9	11	4-56	32	13	12-42	15	47	19-65	15	20	12-57	71	25	16-37
ST ELIZABETH HOSP OF CHICA CHICAGO IL 60622	IL-207	908	13	9-16	52	31	16-42	48	27	17-43	22	27	8-43	57	19	11-33	26	58	23-60	26	15	5-37	62	13	10-31
ST ELIZABETH HOSPITAL BELLEVILLE IL 62222	IL-208	3492	13	10-16	298	30	19-34	141	24	21-38	100	20	11-30	204	20	16-29	84	37	29-51	48	10	11-38	336	24	14-25
ST ELIZABETH HOSPITAL DANVILLE IL 61832	IL-209	1684	14	8-15	130	38	17-35	63	33	18-41	47	15	6-30	76	22	14-33	71	49	26-49	29	24	8-40	154	14	13-28
ST ELIZABETH MEDICALLCENTE GRANITE CITY IL 62040	IL-210	1744	12	9-15	99	34	17-38	62	35	19-42	24	8	8-41	88	26	15-33	57	51	27-53	45	13	8-34	160	21	13-28
ST FRANCIS HOSPITAL BLUE ISLAND IL 60406	IL-211	3088	12	9-16	215	25	18-35	125	30	20-38	37	24	8-35	245	24	16-28	100	24	27-48	75	28	12-35	206	25	14-27
ST FRANCIS HOSPITAL EVANSTON IL 60202	IL-212	3476	13	11-17	227	25	20-36	104	25	21-40	76	29	14-35	172	26	18-32	156	41	33-50	65	20	11-34	328	25	18-30
ST FRANCIS HOSPITAL LITCHFIELD IL 62056	IL-213*	963	13	11-18	67	42	21-46	35	37	19-50	26	23	6-36	59	14	14-37	51	37	29-57	14	7	3-45	73	22	14-35
ST FRANCIS MEDICAL CENTER PEORIA IL 61637	IL-214*	3953	10	8-15	309	26	22-37	134	28	21-37	85	11	9-28	136	24	16-31	139	45	29-47	57	7	5-28	236	16	14-27
ST FRANCIS XAVIER CABRINI CHICAGO IL 60607	IL-215	793	11	8-16	32	28	12-43	23	17	12-48	13	15	7-52	68	28	15-36	13	38	15-64	33	12	11-43	78	13	11-30
ST JAMES HOSPITAL CHICAGO HEIGHTS IL 60411	IL-216	2302	15	10-17	174	27	16-33	92	30	21-40	44	18	11-37	126	27	15-31	85	48	31-53	56	32	10-35	221	26	16-30
ST JAMES HOSPITAL PONTIAC IL 61764	IL-217*	743	12	9-16	40	25	16-45	26	23	16-51	10	20	7-58	38	26	11-38	18	61	20-64	19	21	8-47	69	22	13-34
ST JOHNS HOSPITAL SPRINGFIELD IL 62702	IL-218	5903	10	8-14	434	25	21-35	136	27	21-38	93	19	12-31	266	23	18-30	183	36	29-46	85	34	17-39	388	15	15-26
ST JOSEPH HOSP ELGIN IL 60120	IL-219	1465	15	9-16	123	26	17-36	38	39	15-44	33	18	6-34	80	29	15-34	26	35	23-60	38	18	8-36	130	36	16-32
ST JOSEPH HOSP MEDICAL CEN BLOOMINGTON IL 61701	IL-220	850	14	10-17	72	26	17-41	45	24	17-43	11	27	7-56	51	29	14-37	34	53	26-60	9	22	4-57	54	24	11-34
ST JOSEPH MEMORIAL HOSPITA MURPHYSBORO IL 62966	IL-221	623	13	9-17	43	33	17-46	22	36	15-53	12	0	3-47	37	19	11-39	23	30	19-57	9	22	3-54	76	20	10-29
ST JOSEPHS HOSP CHICAGO IL 60657	IL-222	2424	10	10-16	178	31	18-35	71	20	19-41	65	15	11-34	129	13	16-32	100	27	31-52	47	15	9-36	174	21	17-31
ST JOSEPHS HOSPITAL ALTON IL 62002	IL-223	613	12	8-16	32	28	12-44	16	38	11-53	14	29	4-45	30	13	11-41	21	57	23-64	19	21	8-46	59	17	11-33
ST JOSEPHS HOSPITAL BELVIDERE IL 61008	IL-224	439	13	9-17	21	14	8-44	11	45	11-61	13	15	3-46	40	25	13-40	11	55	17-70	11	27	5-53	40	18	10-36
ST JOSEPHS HOSPITAL BREESE IL 62230	IL-225*	626	9	11-19	29	17	15-50	20	15	14-54	11	0	6-54	29	28	13-45	32	22	30-64	17	12	6-46	84	19	13-32
ST JOSEPHS HOSPITAL HIGHLAND IL 62249	IL-226	577	13	9-17	28	43	12-46	15	27	11-54	18	17	6-44	27	15	11-43	13	62	22-72	11	27	6-56	65	18	16-39
ST JOSEPHS MEDICAL CENTER JOLIET IL 60435	IL-227	3462	12	9-15	255	26	18-34	141	25	19-35	57	16	9-32	236	24	17-29	103	40	30-50	125	16	9-28	230	24	15-28
ST MARGARETS HOSPITAL SPRING VALLEY IL 61362	IL-228	811	12	11-18	81	36	19-42	54	13	18-42	24	38	10-45	38	29	13-40	22	45	21-61	22	9	10-47	67	18	13-34

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST ANTHONYS HOSPITAL CHICAGO IL 60623	6	33	3-67	19	32	17-60	18	6	2-33	1	0	0-100	62	6	1-14	21	5	1-29	4	0	0-100	49	4	1-15	35	0	0-22
ST ANTHONYS MEMORIAL HOSPI EFFINGHAM IL 62401	11	9	9-62	16	44	22-69	49	4	3-21	25	0	0-56	184	7	2-10	98	3	1-13	5	0	0-100	77	9	2-13	89	2	0-8
ST BERNARD HOSPITAL CHICAGO IL 60621	10	50	7-62	[illegible]	25	10-85	14	0	1-39	1	0	0-100	62	6	1-14	23	13	2-29	3	0	0-100	86	7	1-11	47	2	0-16
ST CLEMENT HOSPITAL RED BUD IL 62278	10	20	7-62	3	33	3-84	16	0	4-40	.	.		118	7	3-12	36	11	2-22	[illegible]	0	0-100	71	6	2-14	33	3	0-19
ST ELIZABETH HOSP OF CHICA CHICAGO IL 60622	6	17	2-66	11	27	14-67	15	20	3-40	1	0	0-100	92	5	2-13	36	6	1-21	7	0	0-100	74	7	1-12	46	2	0-15
ST ELIZABETH HOSPITAL BELLEVILLE IL 62222	22	59	14-57	74	46	26-52	120	10	6-18	31	0	0-42	310	6	3-9	154	4	3-13	37	0	0-24	224	2	3-9	218	2	1-6
ST ELIZABETH HOSPITAL DANVILLE IL 61832	14	36	5-52	10	70	13-68	53	[illegible]	3-20	7	0	0-100	163	[illegible]	2-10	63	5	1-15	9	0	0-99	145	10	2-10	94	1	0-8
ST ELIZABETH MEDICALLCENTE GRANITE CITY IL 62040	4	0	1-76	30	40	22-58	47	13	3-22	9	0	0-99	163	4	2-9	84	6	2-16	8	0	0-100	173	5	2-9	92	0	0-8
ST FRANCIS HOSPITAL BLUE ISLAND IL 60406	31	29	12-49	52	33	24-53	70	[illegible]	4-20	33	3	0-54	311	3	3-9	116	4	2-13	21	0	0-91	407	6	3-8	144	3	1-7
ST FRANCIS HOSPITAL EVANSTON IL 60202	19	16	10-54	75	51	26-52	86	7	4-18	32	0	0-64	246	5	4-11	147	11	3-14	20	0	0-36	753	4	3-7	150	1	0-6
ST FRANCIS HOSPITAL LITCHFIELD IL 62056	6	50	6-72	7	57	14-77	31	19	4-28	3	0	0-100	125	5	4-14	39	3	1-20	8	0	0-100	63	2	2-15	57	4	0-12
ST FRANCIS MEDICAL CENTER PEORIA IL 61637	75	15	11-40	21	29	22-64	110	14	4-16	40	3	0-23	376	6	4-10	143	5	2-12	27	0	0-44	396	5	3-8	306	0	0-4
ST FRANCIS XAVIER CABRINI CHICAGO IL 60607	10	30	5-59	4	50	12-88	6	33	2-64	4	0	0-90	70	1	2-14	32	6	2-25	2	0	0-100	116	3	2-10	33	3	0-24
ST JAMES HOSPITAL CHICAGO HEIGHTS IL 60411	20	30	8-51	37	38	21-54	55	9	4-22	5	0	0-100	237	8	4-11	122	9	3-14	18	0	0-64	210	5	3-9	127	2	0-7
ST JAMES HOSPITAL PONTIAC IL 61764	6	17	8-75	5	40	10-81	26	12	2-27	.	.		104	4	2-13	25	[illegible]	1-26	6	0	0-95	62	3	2-14	59	0	0-12
ST JOHNS HOSPITAL SPRINGFIELD IL 62702	30	20	9-46	12	42	18-70	132	13	6-18	123	[illegible]	0-6	459	5	3-9	241	4	1-10	48	2	0-14	944	6	4-7	460	3	1-4
ST JOSEPH HOSP ELGIN IL 60120	13	46	7-57	15	33	15-61	34	9	2-23	8	0	0-90	158	8	3-11	44	2	1-18	12	8	0-64	86	7	2-12	92	4	0-8
ST JOSEPH HOSP MEDICAL CEN BLOOMINGTON IL 61701	8	25	4-63	8	75	20-81	27	11	2-27	8	0	0-100	92	1	2-12	30	7	1-24	8	0	0-100	64	3	1-13	80	4	0-9
ST JOSEPH MEMORIAL HOSPITA MURPHYSBORO IL 62966	6	17	6-71	9	89	16-74	14	0	1-39	.	.		102	4	2-12	34	9	1-22	6	0	0-100	60	[illegible]	2-16	13	0	0-43
ST JOSEPHS HOSP CHICAGO IL 60657	22	14	7-47	38	50	27-61	41	5	3-23	33	0	0-45	214	5	3-11	91	2	2-15	13	0	0-97	230	6	3-9	135	1	1-7
ST JOSEPHS HOSPITAL ALTON IL 62002	5	40	5-75	5	20	4-73	16	13	1-35	8	0	0-100	49	2	1-16	32	9	1-23	12	0	0-99	49	2	1-15	38	3	0-21
ST JOSEPHS HOSPITAL BELVIDERE IL 61008	5	0	3-72	5	40	13-84	9	11	1-50	1	0	0-100	52	8	2-18	30	0	1-23	5	0	0-100	34	3	1-19	26	0	0-24
ST JOSEPHS HOSPITAL BREESE IL 62230	6	0	7-74	1	0	2-98	19	21	3-35		.		84	1	2-13	31	3	3-27	6	0	0-90	39	3	1-18	34	0	0-18
ST JOSEPHS HOSPITAL HIGHLAND IL 62249	1	100	0-98	9	44	11-68	10	10	1-47	4	0	0-100	79	10	2-14	29	10	2-25	2	0	0-100	53	4	1-15	24	0	0-36
ST JOSEPHS MEDICAL CENTER JOLIET IL 60435	20	20	6-48	33	33	23-58	115	10	4-17	15	0	0-86	374	7	3-9	139	5	1-12	17	0	0-66	264	6	3-8	228	4	0-5
ST MARGARETS HOSPITAL SPRING VALLEY IL 61362	11	36	15-70	6	33	9-75	18	6	1-33	1	0	0-100	115	1	2-12	37	0	0-21	8	0	0-100	70	3	2-15	47	0	0-15

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST MARY HOSPITAL QUINCY IL 62301	IL-229	1409	9	8-15	97	15	14-34	57	12	19-43	21	14	3-36	67	18	15-36	36	33	24-56	37	19	7-35	123	20	14-30
ST MARY OF NAZARETH HOSPIT CHICAGO IL 60622	IL-230	1494	11	8-15	111	31	19-39	36	36	17-47	37	11	9-37	67	18	14-35	44	50	23-52	36	11	7-35	91	25	11-29
ST MARY'S HOSPITAL GALESBURG IL 61401	IL-231*	1334	12	9-16	101	17	14-34	46	28	20-47	35	29	13-43	74	19	14-33	35	60	26-59	25	28	11-46	111	21	14-32
ST MARYS HOSP CENTRALIA IL 62801	IL-232	1564	13	9-16	71	30	20-44	40	25	17-46	23	13	8-43	90	28	14-32	49	57	28-57	58	34	13-38	184	21	15-29
ST MARYS HOSP KANKAKEE IL 60901	IL-233	1757	12	9-16	95	28	18-39	64	34	17-40	50	12	8-32	114	23	15-31	64	36	25-49	58	16	12-37	158	20	13-28
ST MARYS HOSPITAL DECATUR IL 62525	IL-234*	2839	11	8-15	169	30	19-36	94	36	20-40	62	11	8-30	160	27	17-31	87	46	28-50	27	7	6-38	220	15	15-29
ST MARYS HOSPITAL EAST SAINT LOUIS IL 62201	IL-235	861	10	8-15	36	25	17-48	28	14	15-48	26	31	7-38	59	14	11-33	21	52	19-59	32	22	9-40	84	12	11-29
ST MARYS HOSPITAL STREATOR IL 61364	IL-236	1369	11	10-17	74	34	18-42	49	24	18-44	29	7	9-40	89	28	13-31	44	41	24-53	68	7	10-33	143	15	15-30
ST THERESE MEDICAL CENTER WAUKEGAN IL 60085	IL-237	1696	14	9-16	138	42	19-37	53	34	19-45	34	26	8-36	91	22	15-33	44	41	26-55	52	21	10-36	169	23	12-26
ST VINCENT MEMORIAL HOSP TAYLORVILLE IL 62568	IL-238*	788	12	9-17	32	31	14-46	15	40	13-58	13	38	8-54	34	26	14-43	26	46	22-59	14	29	8-53	77	19	14-34
SUBURBAN HOSP AND SANITARI HINSDALE IL 60521	IL-239*	422	15	9-18	29	21	9-41	8	50	10-68	17	12	4-40	24	29	9-43	6	33	15-82	16	38	10-53	45	27	13-39
SWEDISH AMERICAN HOSPITAL ROCKFORD IL 61101	IL-240	2580	13	9-15	251	27	19-35	56	38	19-43	59	22	10-32	130	18	15-31	91	37	28-49	49	22	9-35	164	24	14-29
SWEDISH COVENANT HOSPITAL CHICAGO IL 60625	IL-241	2082	15	11-18	158	22	16-33	93	34	21-41	44	25	9-34	155	25	18-32	80	48	32-54	42	19	9-37	164	29	18-33
SYCAMORE MUNICIPAL HOSPITA SYCAMORE IL 60178	IL-242*	225	11	11-22	22	9	9-45	11	36	11-62	9	0	5-58	11	18	8-57	13	38	16-65	4	25	6-81	23	30	11-46
THE HOSP OF ENGLEWOOD CHICAGO IL 60621	IL-243*	312	13	7-17	11	55	8-58	19	21	12-51	4	0	2-74	22	23	7-41	9	56	11-66	11	18	6-54	32	16	8-36
THOMAS H BOYD MEMORIAL HOS CARROLLTON IL 62016	IL-244*	156	21	9-22	4	50	9-85	6	67	5-67	4	0	0-75	6	33	5-68	7	43	12-75	11	9	3-49	31	35	15-47
THOREK HOSPITAL AND MEDICA CHICAGO IL 60613	IL-245	488	9	7-15	27	11	12-45	10	0	7-59	3	0	0-82	29	24	11-41	9	78	14-71	7	14	7-67	49	16	8-30
UMWA UNION HOSPITAL WEST FRANKFORT IL 62896	IL-246*	501	15	9-18	16	38	6-47	13	15	10-57	21	24	7-42	31	39	13-44	21	24	19-59	20	25	5-42	55	16	10-32
UNION COUNTY HOSPITAL ANNA IL 62906	IL-247	411	13	8-17	13	38	7-52	16	44	14-57	11	9	3-49	19	26	10-48	8	25	15-75	13	15	4-48	65	15	11-32
UNIVERSITY OF CHICAGO MEDI CHICAGO IL 60637	IL-248	2375	11	9-16	272	28	22-37	71	31	17-39	59	15	12-35	91	15	16-34	83	24	27-49	48	17	9-35	123	17	13-29
UNIVERSITY OF ILLINOIS HOS CHICAGO IL 60612	IL-249	1482	8	6-13	121	25	16-35	43	19	14-40	23	22	6-40	53	9	10-32	40	33	24-54	34	12	7-36	76	12	8-26
US AIR FORCE HOSP BELLEVILLE IL 62225	IL-250*	3	100	0-91	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
US AIR FORCE HOSP RANTOUL IL 61866	IL-251*	1	100	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VICTORY MEMORIAL HOSPITAL WAUKEGAN IL 60085	IL-252*	1866	12	10-17	128	15	15-33	77	27	19-40	32	19	8-37	114	20	16-33	58	34	28-54	63	22	10-34	182	26	15-29
WABASH GENERAL HOSPITAL DI MT CARMEL IL 62863	IL-253	436	15	9-18	16	31	8-50	20	25	15-54	17	18	6-45	16	25	9-50	17	35	20-64	18	17	3-39	52	38	12-36
WALTHER MEM HOSP CHICAGO IL 60651	IL-254*	389	9	6-15	15	13	5-45	8	0	11-70	9	44	5-57	33	21	11-39	9	44	11-67	9	44	4-57	38	5	6-31

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST MARY HOSPITAL QUINCY IL 62301	3	0	7-89	23	30	18-58	38	16	3-25	50	0	0-18	135	7	2-11	73	10	1-15	18	0	0-95	80	4	2-13	89	3	0-9
ST MARY OF NAZARETH HOSPIT CHICAGO IL 60622	7	29	5-67	14	50	13-61	30	7	4-29	3	0	0-100	161	9	3-12	47	2	1-18	6	0	0-100	178	3	2-9	99	2	0-8
ST MARY'S HOSPITAL GALESBURG IL 61401	9	67	9-67	13	54	17-67	45	4	3-22	11	0	0-99	144	3	2-11	86	5	1-13	20	0	0-82	95	4	2-13	115	0	0-7
ST MARYS HOSP CENTRALIA IL 62801	11	27	5-57	8	25	10-69	32	3	3-27	39	3	0-37	141	7	3-12	59	3	2-17	13	0	0-98	169	2	3-10	102	1	0-8
ST MARYS HOSP KANKAKEE IL 60901	13	38	8-58	34	32	21-55	39	5	3-24	26	0	0-61	175	6	2-10	104	5	2-13	14	0	0-100	162	3	2-9	105	1	0-8
ST MARYS HOSPITAL DECATUR IL 62525	23	30	14-56	19	16	18-61	90	7	4-18	35	0	0-42	332	5	3-9	132	2	2-12	25	0	0-94	155	8	2-9	233	0	0-5
ST MARYS HOSPITAL EAST SAINT LOUIS IL 62201	9	22	4-59	4	25	8-83	8	13	1-53	1	0	0-100	51	2	1-16	38	5	2-21	1	0	0-100	59	2	1-13	30	3	0-22
ST MARYS HOSPITAL STREATOR IL 61364	12	25	14-67	22	9	20-61	38	8	3-24	4	0	0-100	151	5	2-11	43	7	3-22	14	0	0-82	126	2	2-11	76	1	0-10
ST THERESE MEDICAL CENTER WAUKEGAN IL 60085	17	12	7-51	34	29	20-54	27	0	1-25	11	0	0-97	161	7	3-11	58	10	3-19	14	0	0-85	127	6	2-10	106	1	0-8
ST VINCENT MEMORIAL HOSP TAYLORVILLE IL 62568	7	43	9-72	5	40	8-78	20	5	2-33	.	.		95	7	4-15	51	6	3-21	4	0	0-100	90	2	2-13	40	5	0-16
SUBURBAN HOSP AND SANITARI HINSDALE IL 60521	5	40	3-72	10	20	15-70	13	15	1-40	3	0	0-100	39	3	1-18	30	13	3-28	3	0	0-94	40	5	2-19	19	0	0-36
SWEDISH AMERICAN HOSPITAL ROCKFORD IL 61101	22	23	9-50	24	58	21-61	69	12	4-20	46	0	0-52	289	6	3-10	123	5	2-12	28	0	0-82	251	11	3-8	154	1	0-6
SWEDISH COVENANT HOSPITAL CHICAGO IL 60625	19	42	14-59	17	35	17-62	34	24	3-26	17	0	0-67	174	7	3-12	146	4	3-13	14	0	0-72	154	5	2-10	88	3	0-9
SYCAMORE MUNICIPAL HOSPITA SYCAMORE IL 60178	2	100	7-96	3	0	3-83	1	0	0-100	.	.		29	0	1-24	15	7	1-37	3	0	0-100	20	0	1-28	4	0	0-95
THE HOSP OF ENGLEWOOD CHICAGO IL 60621	2	50	2-90	4	50	5-79	4	25	0-78	.	.		22	9	2-29	6	0	0-78	.	.		40	8	1-17	7	0	0-100
THOMAS H BOYD MEMORIAL HOS CARROLLTON IL 62016	2	100	3-91	.	.		.	.		.	.		11	9	0-46	3	0	0-96	1	0	0-100	12	0	0-42	4	25	0-98
THOREK HOSPITAL AND MEDICA CHICAGO IL 60613	6	17	3-68	3	33	4-85	5	0	1-68	6	0	0-78	58	2	2-17	22	0	2-31	5	0	0-100	58	2	1-14	40	3	0-16
UMWA UNION HOSPITAL WEST FRANKFORT IL 62896	14	29	8-56	18	33	16-59	16	6	1-35	1	0	0-100	50	2	1-16	13	8	2-42	5	0	0-100	68	4	1-13	5	0	0-100
UNION COUNTY HOSPITAL ANNA IL 62906	7	29	3-64	6	67	9-75	24	17	2-28	.	.		52	4	2-17	6	0	0-87	3	0	0-100	27	7	1-24	28	0	0-25
UNIVERSITY OF CHICAGO MEDI CHICAGO IL 60637	55	9	5-36	9	56	12-69	40	18	4-25	30	0	0-52	171	8	3-11	86	1	2-15	18	0	0-85	176	11	2-10	108	0	0-7
UNIVERSITY OF ILLINOIS HOS CHICAGO IL 60612	32	6	2-38	3	100	10-91	17	12	1-34	133	0	0-6	84	0	2-13	65	5	1-16	12	0	0-100	103	6	1-10	76	1	0-10
US AIR FORCE HOSP BELLEVILLE IL 62225	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
US AIR FORCE HOSP RANTOUL IL 61866	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VICTORY MEMORIAL HOSPITAL WAUKEGAN IL 60085	21	24	14-57	18	44	19-64	53	8	5-24	8	0	0-94	173	4	3-12	60	5	1-16	23	0	0-37	184	3	3-9	124	0	1-7
WABASH GENERAL HOSPITAL DI MT CARMEL IL 62863	3	67	5-86	8	13	10-70	7	29	0-60	2	0	0-100	39	5	1-18	16	13	2-36	3	0	0-93	59	7	1-14	14	0	0-55
WALTHER MEM HOSP CHICAGO IL 60651	1	0	0-99	.	.		7	14	1-57	.	.		43	5	1-18	28	4	0-25	2	0	0-100	48	4	1-17	25	0	0-65

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WASHINGTON COUNTY HOSPITAL NASHVILLE IL 62263	IL-255*	389	20	13-22	23	35	11-48	26	23	14-48	1	0	1-97	26	27	12-45	20	60	23-65	26	19	12-48	76	37	16-37
WEST SUBURBAN HOSPITAL MED OAK PARK IL 60302	IL-256*	2291	12	9-16	229	25	15-31	55	29	19-44	52	12	9-32	119	16	16-32	73	32	27-50	52	13	10-36	186	22	16-30
WESTLAKE COMMUNITY HOSPITA MELROSE PARK IL 60160	IL-257	1854	12	9-15	111	38	18-38	53	25	18-44	45	11	7-31	119	25	15-31	52	38	27-55	57	12	10-34	89	20	13-31
WHITE HALL HOSPITAL WHITE HALL IL 62092	IL-258*	227	17	9-20	3	67	0-82	12	50	11-60	3	0	1-81	15	33	8-49	4	25	8-83	16	19	8-51	43	21	12-39
WOOD RIVER TOWNSHIP HOSPIT WOOD RIVER IL 62095	IL-259	688	14	8-16	27	26	16-51	17	53	13-55	9	22	5-59	45	33	12-37	26	31	21-57	12	50	7-55	64	28	13-35
WOODLAWN HOSPITAL CHICAGO IL 60637	IL-260*	46	17	4-24	3	33	1-82	2	0	1-89	2	50	1-89	3	67	3-82	1	100	1-97	3	0	0-84	2	0	0-90

*Written Comments Not Submitted

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WASHINGTON COUNTY HOSPITAL NASHVILLE IL 62263	.	.		.	.		11	0	1-45	1	0	0-100	41	7	2-19	7	0	0-58	7	0	0-100	22	0	1-28	17	0	0-38
WEST SUBURBAN HOSPITAL MED OAK PARK IL 60302	24	17	7-46	29	34	22-58	75	7	4-19	20	0	0-88	274	7	3-10	134	4	2-12	17	6	0-60	170	6	2-9	151	3	0-6
WESTLAKE COMMUNITY HOSPITA MELROSE PARK IL 60160	16	13	10-56	29	28	18-54	24	17	3-30	8	0	0-99	166	8	2-10	68	7	2-17	14	0	0-100	240	2	2-8	90	3	0-9
WHITE HALL HOSPITAL WHITE HALL IL 62092	2	50	1-90	4	25	7-82	1	0	0-100	.			31	19	1-21	5	20	3-69	1	0	0-100	20	0	0-28	7	0	0-68
WOOD RIVER TOWNSHIP HOSPIT WOOD RIVER IL 62095	6	33	4-69	4	50	8-84	12	0	2-44	2	0	0-100	49	12	2-17	31	3	1-23	5	0	0-100	38	3	1-19	53	0	0-15
WOODLAWN HOSPITAL CHICAGO IL 60637	1	0	0-99	.	.		.	.		.	.		4	0	0-75	.	.		1	0	0-100	6	17	0-74	3	0	0-100

*Written Comments Not Submitted.

ABRAHAM LINCOLN
MEMORIAL HOSPITAL

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
6325 Security Blvd
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for the opportunity to comment on the mortality information concerning Abraham Lincoln Memorial Hospital.

Though we were only slightly higher than the predicted mortality in two categories; severe chronic heart disease one percent higher, and severe acute heart disease two percent higher, we believe there is information we feel pertinent to share with respect to mortality information.

1. The mortality data does not measure the quality of care given. Our hospital already has an internal Quality Assurance program which reviews all deaths for the appropriateness of the care and treatment given. This review has not revealed problems in either of the two areas which fell out of the HCFA predicted norm.

2. Our hospital experienced a higher percentage of deaths in the areas of severe acute heart disease and severe chronic heart disease because the patients with treatable forms of heart disease are transferred to tertiary facilities for the additional acute care and diagnostic studies they require.

3. In support of this, the quality assurance committee found that 46 percent of the patients in the category of severe acute heart disease, who expired, were "no code" patients. The patients or their families had requested no heroic treatment while in the hospital and subsequently the patients expired.

4. The credibility of the mortality rate statistics for our hospital is questionable given the few patients hospitalized here in these two categories.

Again, we appreciate this opportunity to comment and hope that these

comments will be shared with the public to the same extent that the statistical information is shared with them.

Sincerely,

D. DAVID SNIFF
President
and Chief Executive Officer

DDS/gl

cc: G. E. Blaum, M.D., Chairman
Utilization Review
James Broadway, VP, IHA

ALEXIAN BROTHERS
Medical Center

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

The statistics that are presented by the Health Care Financing Administration are flawed. This is true not only for Alexian Brothers Medical Center (ABMC) but for all hospitals as well. Areas where flawed logic was applied are as follows:

1) The manner in which HCFA statistics are displayed presents an overestimate of the probability of a hospital stay resulting in death. The data are based on the <u>one</u> discharge during/after which a Medicare patient died. This means that the previous discharges of that same patient for which treatment was successful (i.e., the patient did <u>not</u> die) are ignored. These are discharges which truly indicate the quality of the care a hospital provided to successfully extend and sustain the life of that patient.

2) The sample of cases is biased toward those resulting in death. The results present a higher than expected death rate for hospitals caring for larger than average number of terminally ill. Hospitals with inpatient hospice units (such as ABMC) voluntarily give quality care to the terminally ill and help them prepare for death.

3) Deaths may be unrelated to the condition of the patient at discharge, e.g., after cataract surgery, a patient dies of a heart attack at home. Based on six (6) months statistics, ABMC has <u>no</u> information as to the cause of death for 17.8% of former patients who died elsewhere. Yet the cause of death for these patients is attributed to the diagnosis at the last discharge from the hospital-if HFCA's method is used.

4) Severity of illness has been overlooked. The categories of illness are too broad. For example, certain forms of cancer are less likely to terminate in death than are others. Yet, the implication seems to be that all cancers end in death.

5) Mortality rates do not measure quality of care. A terminal patient who has been cared for at home and dies upon arrival at the hospital becomes a mortality statistic for the hospital. In

no way does this indicate the quality of care that is continually administered by the hospital. Inaccurate conclusions may be drawn if only mortality rates are published.

6) The "Range of Predicted Mortality Rates" is confusing. There is no explanation as to their meaning nor any information as to their derivation. How accurate will the interpretation be, especially by those who are not familiar with statistics?

7) The delivery of quality care is the highest priority at ABMC. The quality of care is monitored through the peer review process and a comprehensive quality management program. The quality of care should be the basis upon which an individual selects a hospital for their health care needs. Reporting mortality rates exclusively makes what is only a part of a picture become a total picture. The public, then, receives totally distorted information about a hospital. This can lead to uncalled for fears and incorrect conclusions and perceptions.

8) The sample focuses on the Medicare population, which is only a portion of the total population serviced by a hospital. This is a population that has special health care needs not addressed in this report. The health status of this population is compounded by advanced age as well as many preexistent health care conditions. However, the public is being led to make a judgement based upon this small compromised population (e.g. 185 Medicare cases out of the 14,000 cared for in one year at ABMC). This is unfair not only to the hospital but to the public as well.

We would appreciate that consideration be given to the points addressed in this letter.

Sincerely,

Brother Philip Kennedy

Brother Philip Kennedy
President/Chief Executive Officer

Ronald B. McMullen • President
618/463-7311
ALTON MEMORIAL HOSPITAL ONE MEMORIAL DRIVE • ALTON, ILLINOIS 62002

October 15, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Resources
Washington, D.C. 20201

Dear Mr. Roper:

Alton Memorial Hospital appreciates the opportunity to comment on our hospital's specific mortality data from the Health Care Financing Administration.

We have examined the report and are pleased to see that Alton Memorial Hospital falls well within expected statistical mortality rates for the diagnostic categories you examined.

However, we wish to point out the deaths that occurred outside the hospital are beyond our control.

Of the 30 cases that the deaths occurred outside of Alton Memorial Hospital, 4 deaths were at another hospital, 13 were in nursing facilities, 4 were at home, 5 were at an unknown place, and 4 were DOAs.

Again, we appreciate the chance to comment on the mortality statistics.

Sincerely,

Ronald B. McMullen

Ronald B. McMullen
President

American International Hospital

Shiloh Boulevard
& Emmaus Avenue
Zion, Illinois 60099
Telephone: 312.872.4561

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Roper:

In follow up to the mortality information provided to us, to be published in December 1987, we submit the following comments:

PATIENT ID NUMBER (HIC)	SURNAME	COMMENTS
[redacted]	[redacted]	Date of death stated as 9-30-86. Patient expired at American International Hospital on 9-12-86. Principal diagnosis correct.
[redacted]	[redacted]	Patient discharged to nursing home in stable condition on 1-10-86. Pronounced DOA in Emergency Room on 1-13-86. Patients family requested that no heroic measures be taken.
[redacted]	[redacted]	Patient discharged to nursing home in stable condition on 10-3-86, expired on 10-10-86. Patients family requested that no heroic meausres be taken.
[redacted]	[redacted]	Date of death stated as 7-31-86. Patient expired at American International Hospital on 7-24-86. Principal diagnosis correct.
[redacted]	[redacted]	Principal diagnosis stated as 71481. Correct principal diagnosis was 5184.
[redacted]	[redacted]	Patient discharged to nursing home in stable condition on 1-31-86, expired 2-16-86. Patients family requested that no heroic measures be taken.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

PATIENT ID NUMBER (HIC)	SURMANE	COMMENTS
[redacted]	[redacted]	Patient discharged to nursing home in stable condition on 6-13-86, expired 6-25-86. Patients family had requested no heroic measures be taken.
[redacted]	[redacted]	Date of death stated as 3-31-86. Patient expired at American International Hospital on 3-11-86. Principal diagnosis correct.
[redacted]	[redacted]	Patient expired on 10-20-86 following 10-17-86 discharge. Patients family requested that no heroic measures be taken.
[redacted]	[redacted]	Patient discharged to nursing home on 12-19-86 with bronchitis and early pneumonia due to gastric aspiration. Discharged on IV antibiotics and with feeding gastrostomy. Returned to ER on 12-20-86 where pronounced expired.
[redacted]	[redacted]	Patient discharged to nursing home in stable condition on 12-10-86. Expired 12-25-86. Patients family had requested that no heroic meausres be taken.
[redacted]	[redacted]	Patient discharged to nursing home on 6-6-86 with indwelling catheter, nasogastric tube and anti-biotic IM. Brought back to ER DOA on 6-7-86. Patients family requested that no heroic measures be taken.
[redacted]	[redacted]	88 year old female admitted on 4-13-86 and expired 4-21-86. Principal diagnosis 586. PATIENT NOT ON REPORT.
[redacted]	[redacted]	66 year old male admitted on 3-25-86 and expired 4-2-86. Principal diagnosis 5724. PATIENT NOT ON REPORT.

Thank you for the opportunity to review this information.

Sincerely,

Mary Jean Kelley
Assistant Administrator

MJK/bks

Lutheran General Hospital
Lincoln Park

2035 North Lincoln Avenue
Chicago, Illinois 60614

Telephone 312/975-5000

October 21, 1987

Mr. William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Re: HCFA Mortality Data
Augustana Hospital & Health Care Center
Medicare Provider # 14-0017

Dear Mr. Roper:

In regards to your letter of September 21, 1987, which details HCFA's mortality rates for Augustana Hospital (now Lutheran General Hospital - Lincoln Park) we have several comments in regard to methodology and errors we have identified. We are comfortable that our concerns will be addressed in the future and improvements will continue with the system.

In this world of increasing public accountability, we do realize that HCFA is obligated to present information on the quality of care given to the Medicare beneficiary. Although the mortality rates which incorporate a case mix element are the "best" method currently, it will remain inadequate until the severity of illness and/or comorbidity on an individual case basis is used. Of the twenty-three cases classified in the low risk categories or expired after discharge, 65% or 15 cases fell into Class III or IV on ASCORE scale of I - IV for severity of illness. A final diagnosis, other than metastatic carcinoma, does not necessarily indicate any pre-existing and/or terminal medical condition(s).

We have noted a few errors in the data presented. These include dates (both hospitalization and expiration), principle diagnosis, and mortality status. These are listed separately on the attachment. These corrections will affect our mortality rate report.

Our major concern is the methodology used in counting and defining cases. Augustana's mortality rates fall within or well below HCFA's predicted levels with an overall rate of 10% (100 out of 1001 cases). Using HCFA's definitions, we arrive at a overall mortality rate of 9.6% (118 out of 1229 cases). The absence of the 228 cases helps to inflate our rate as calculated by HCFA. Also please note our HCFA rate is inflated by 1 mortality (see attachment) in category GI, which lowers our hospital HCFA rate to 9.9% and

our GI rate to 6.2%. The methodology for defining a case seems to artificially inflate mortality rates. Another method to define "case" could be each individual admission and discharge from the hospital. This would incorporate each successful hospital admission into the statistic, thereby allowing recognition of the potential for unforeseen complications on any admission. In your letter, the desire to answer the question "What is the actual death rate...?" is stated. By grouping multiple admissions for an individual into one case, you artificially drive the expected death rate up. When all admissions are used to calculate a mortality rate, Augustana's rate is 6.7% (118 deaths out of 1772 cases). Since it is HCFA's desire to present accurate mortality rates, the case definition must be addressed for future studies.

Despite some concerns we congratulate HCFA on the improvements in its methodology and for the opportunity to comment on the data.

Thank you for allowing us the opportunity to comment on these statistics.

Sincerely,

David M. A. Jensen
Senior Vice President &
Chief Operating Officer

William Dalessandro, M.D.
President - Medical Staff

DMAJ/WD/cjg

0001G

AUGUSTANA (LUTHERAN GENERAL HOSPITAL - LINCOLN PARK)

ATTACHMENT

PATIENT NUMBER	CATEGORY	COMMENTS
[redacted]	GI	Alive and well. Last office visit 9/14/87.
[redacted]	UN	Last adm: 5/30-6/9/86. Expired 6/9/86.
[redacted]	UN	Exp. 9/26/86 not 9/27/86.
[redacted]	PN	Adm. 7/15-7/17/86. Exp. 7/17/86
[redacted]	SE	Principle diagnosis changed to 434.0. Diagnostic category unchanged.
[redacted]	SE	Principle diagnosis changed to 038.1. Diagnostic category unchanged.
[redacted]	UN	Principle diagnosis changed to 428.0. Diagnostic category changed to HM.
[redacted]	UN	Principle diagnosis changed to 197.6. Diagnostic category changed to CA.
[redacted]	UN	Principle diagnosis changed to 995.2. Diagnostic category unchanged.
[redacted]	HS	Principle diagnosis changed to 416.8. Diagnostic category changed to HL.

Evangelical Health Systems

Bethany Hospital
3435 West Van Buren, Chicago, Illinois 60624 (312) 256-7700

HCFA DATA ANALYSIS

BETHANY HOSPITAL welcomes the opportunity to respond to the recently published HCFA mortality data. Bethany Hospital's actual mortality rates did not fall outside the predicted ranges for any of the diagnostic categories. However, because we feel that mortality data can be appropriately used to guide or focus medical peer review, Bethany Hospital elected to analyze categories where it appeared that the actual rate ranked higher than average in the predicted ranges.

After medical peer review, it was confirmed that the HCFA methodology was not able to account for the severity of the patients' illnesses at the time of admission to the hospital.

For example, in the Sepsis category, all patients who expired were in a terminal stage of illness at the time of admission. All were admitted from nursing homes with not only a principal diagnosis of sepsis, but also many acute co-morbid conditions and acute complications such as renal failure, gangrene, malnutrition, hyponatremia and respiratory failure. Thus, the factors which caused the actual mortality rate to fall into the upper end of the predicted range were patient-specific characteristics which made Bethany's admissions differ significantly from the "average" patient reflected in the HCFA data.

Bethany Hospital acknowledges the value of using mortality statistics as a mechanism with which to screen clinical data and identify areas which warrant a more in-depth focussed review. However, as stated by the JCAH and AHA, Bethany Hospital is aware that statistical indicators are not direct measures of quality; and as demonstrated by the above analysis, any determination about actual quality of patient care can only be made as part of a case-oriented medical peer review process.

BLESSING HOSPITAL
Broadway at 11th Street Quincy, Illinois 62301 (217) 223-5811

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Comments in Response to HCFA Mortality Data
Medicare Provider No. 14-0015

To Whom It May Concern:

Blessing Hospital does not believe mortality rates by themselves are meaningful indicators of the quality, appropriateness or effectiveness of any particular hospital's patient care. Nor does it believe such information should be viewed by physicians, consumers or others as a sound standard for making choices between institutions.

While gathering mortality data on a national basis and using it to compute aggregate statistics can be helpful to individual hospitals in developing methods for measuring their effectiveness, release of this information to the public serves no useful purpose. Such information is meaningful and beneficial only in an environment where the full context of its derivation is understood.

This particular report casts Blessing Hospital in a positive light by showing its mortality rates to be well within acceptable ranges in each catagory identified. Presumably this indicates the quality of care at Blessing is good, at least for Medicare patients. But what if data for the next report shows Blessing to be above or below normal mortality ranges. Will that mean the quality of care it renders has suddenly changed from one reporting period to the next? Of course, it will not. It will mean only that one or more of the many factors impacting mortality among Medicare patients has varied.

Respectfully,

Lawrence L. Swearingen
President

LLS:rk

cc: Hon. Richard J. Durbin, M.C.

VHA.
Affiliate of Voluntary Hospitals of America, Inc.

Burnham Hospital
407 South Fourth Street
Post Office Box No. 4003
Champaign, Illinois 61820
Telephone: (217) 337-2500

October 19, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Please accept this letter as our official comment on the HCFA Mortality Data.

COMMENTS ON HCFA MORTALITY DATA
Burnham Hospital, Champaign, Illinois
Medicare Provider Number: 140126

DATA VERIFICATION

The data used by HCFA indicate that a total of 110 Medicare patients admitted to Burnham Hospital died within 30 days of admission. Of these, 82 died while still a patient of the hospital, while 28 died after discharge. We find this data to be accurate.

INTERPRETIVE REMARKS

We at Burnham Hospital believe that an appropriate assessment of hospital performance is dependent upon many variables and requires a look at many quality indicators, of which mortality is but one. Since the mortality information released by HCFA is not a complete measure of the quality of care we cannot and do not recommend the use of this information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals.

In one of the sixteen HCFA diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. The diagnostic category is renal disease. Several factors may account for this difference.

In this category a total of only seven cases are included in the HCFA review. This represents a very small sampling. In addition to renal disease, the five mortality cases had additional medical problems such as cancer, diabetes, hypertension, sepsis, congestive heart failure and liver failure. These cases were included in the category of renal disease because

the attending physician must list only one acute condition which caused the patient to be admitted to the hospital even though several conditions may have been present. In one of the cases the patient's family decided not to institute resuscitative measures, due to the patient's advanced age and chronic condition. All five patients had multiple organ system failures due to severe chronic disease processes which became acute and precipitated renal failure as well as other system/organ failures. The patients were unresponsive to treatment rendered due to the extent and severity of the disease processes.

Due to Burnham Hospital's status as the Regional Trauma Center our major areas of service are in the following diagnostic categories: severe chronic heart disease, severe acute heart disease, orthopedic disorders and severe trauma. In all of these areas Burnham Hospital's mortality rates are well within the predicted mortality rates. At Burnham Hospital all mortality cases are regularly reviewed by a group of physicians on the appropriate departmental medical committees.

HOSPITAL DESCRIPTION

Burnham Hospital is a 202-bed general and acute care facility. Opened in 1895, Burnham was the first community hospital in Champaign-Urbana and continues to serve the people of the twin cities as a not-for-profit, non-tax-supported institution. The Hospital was designated in 1971 as the Regional Trauma Center for East Central Illinois, covering 16 counties.

Burnham Hospital, owned by the city of Champaign since 1924, is governed by a board of directors appointed by the mayor of Champaign and approved by the City Council. Burnham Hospital is a member of Voluntary Hospitals of America (VHA).

Burnham Hospital recognizes as its prime purpose the provision of high quality, cost efficient patient services in an accessible location. Of utmost concern is the provision of all services with respect, consideration and dignity for the patients and their families. Burnham believes that there should be equitable access to health care and to the extent of its resources will provide these services for all individuals regardless of ability to pay.

Medical and major surgical care, including open heart procedures, orthopedic surgery, and neurosurgery is routinely provided. A full range of treatment and diagnostic services is also available, including radiology, laboratory, respiratory therapy, speech and occupational therapy, physical therapy, EKG, EEG, and

cardiac catheterization. In addition to its trauma, orthopedic, cardiac and neurosurgery specialties, Burnham also offers several unique services, including the Woman's Choice Health Center and Tel-Med, a telephone information tape library on over 400 topics. Burnham also owns and operates Professional Ambulance Service.

Burnham Hospital remains dedicated to serving the needs of the Champaign-Urbana community, and sponsors a number of community programs including Safe Rides for Teens, Staying Alive, Tommy Trauma, and Pick-Me-Up.

Sincerely,

Peter E. Goschy
Chief Executive Officer

Carle

Carle Foundation Hospital
611 West Park Street, Urbana, IL 61801 Phone: (217) 337 3311
Medicare Provider #14-0091

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for this opportunity to comment on the release of HCFA's mortality data. As a health care provider interested in evaluating and improving quality of care, Carle Foundation Hospital is particularly interested in the report. While this report is by no means a stand-alone document for evaluating quality and only addresses Medicare patients, it does provide Carle with another source of information to include in our quality review efforts.

Our hospital-specific mortality data has been carefully reviewed by Hospital Administration, the Quality Assurance team and members of the Medical Staff. We are pleased to note that, as measured by this mortality data, Carle and its physicians are providing a level of care that meets or exceeds the standards established in the report. The overall mortality rate for Carle's Medicare patients, approximately 35% of our caseload, is within the ranges that HCFA has defined as expected for those patients. We also found that for two categories, our mortality rate was below the predicted range. To allow us to focus our attention on areas that might need further review, we took a closer look at your statistics and calculated a mean for each range. We found that not only are Carle's mortality rates within the range established as normal in your report, but in most cases the rates are below the mean, that is, better than average.

We would like to point out that Carle's quality assessment activities are not limited to feedback received from external sources. Internally, there are numerous activities, including the review of all deaths. Members of our medical staff take an active role in assessing quality and appropriateness of care provided not only to Medicare patients, but all patients. The HCFA report is helpful because it provides us with information about patients after discharge and allows us to incorporate this post-discharge data into our quality assessment data base.

The greatest challenge before health care providers today is defining and assessing "quality". Although there are some problems associated with the HCFA report, we believe it represents a growing effort on the part of government, consumers, physicians and hospitals to define and measure quality. We encourage HCFA to continue its refinement of the method by which the mortality report is prepared. In particular, we would like to see some effort directed toward incorporating severity of illness into the report. We would also like to have some information/knowledge regarding whether deaths that occurred after discharge were directly related to the most recent hospital stay. As the report stands, we cannot identify causes of death for those patients who expired post-discharge. A death could be completely unrelated to the patient's problem during hospitalization.

Again, thank you for the mortality information and for the opportunity to share our comments with you. We will include it as a part of our ongoing quality assessment activities.

Sincerely,

Stephen R. Humpherys, M.D.
Hospital Medical Director

SRH:sm

Carmi Township Hospital

TELEPHONE 618/382-4171

PLUM AND WEBB STREETS - CARMI, ILLINOIS 62821

October 16, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Hospital Mortality Rate
Medicare Provider No. 14-0107

Dear Sir:

The data relative to hospital mortality rates for this facility has been reviewed and the following comments are offered:

The data, as presented, reveals that this hospital has a favorable experience in all but one category. In fact, the hospital's actual mortality rates are within the lower half of the predicted ranges for thirteen of the diagnostic categories, only 1.5 percentage points above the predicted range midpoint for one, and 2 percentage points above the predicted range for another.

An examination of the data of the one diagnostic category for which this hospital was reported to have exceeded the predicted range of mortality reveals what we feel is a problem in the way the data is reported.

By restricting the data to the last admission of a Medicare patient, the mortality rates are overstated compared to the actual number of admissions cared for by the hospital. If all admissions for the diagnostic category are reported, this facility's data would be as follows:

Diagnostic category: HS - Severe Acute Heart Disease

	Cases	Deaths	Actual Mortality Rate
HCFA reported data	22	14	64%
Hospital calculated data			
All Medicare admissions	49	14	28.6%
All admissions	57	15	12.5%

There is a significant difference in the mortality rates when all admissions are considered versus the last admission. The HCFA reported data is heavily weighted to deaths.

Because very few people who have access to this data will be aware of what it represents, and since none will be aware of what we feel is a more realistic presentation, the HCFA report will falsely imply that each hospital provides a lower quality of care than they actually do.

Based on this analysis of just one factor relative to the data, we believe the public would be best served through withholding release of the mortality data until the methodology of its collection and presentation accurately reflects the true experience of each hospital.

Even though the mortality rates for this hospital are, with one exception, positive, we feel that the data should be revised to accurately reflect the care provided by each facility.

Sincerely,

Michael C. O'Brien
Administrator

MCO:jeb

Central DuPage Hospital

October 15, 1987 CERTIFIED

Dept of Health & Human Services
Health Care Financing Administration
William L. Roper, M.D., Administrator
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

The following is our response to the mortality data released to us by HCFA. For purposes of identification, our Medicare provider number is 140242.

Because of the inclusion of deaths which occurred after discharge and which may not be related to the last admission, the accuracy of all the HCFA data cannot be verified. We are therefore responding only to information contained in our medical record. Of the 16 categories reported by HCFA, the hospital's mortality rate fell well within or below the range of predicted mortality rates in 15 categories.

In one category (metabolic/electrolyte disturbances), our actual mortality rate was 1% above the range of predicted mortality rate. On review of the medical records of these patients, 65% were over 80 years of age (80 years-102 years) and all patients had pre-existing chronic diseases or other associated acute diseases. In general the associated conditions were diabetes, renal failure with dialysis, or wide spread cancer. We have more patients with these conditions due to our large active cancer therapy programs, and the on-site presence of a renal dialysis program.

Thank you for the opportunity of responding to the mortality data.

Sincerely,

George G. Holzhauer
President

25 North Winfield Road
Winfield, Illinois 60190
312-682-1600

Chicago Osteopathic Medical Center
5200 South Ellis Avenue
Chicago, Illinois 60615
(312) 947-3000

Olympia Fields Osteopathic Medical Center
20201 South Crawford Avenue
Olympia Fields, Illinois 60461
(312) 747-4000

CHICAGO OSTEOPATHIC MEDICAL CENTERS

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: MEDICARE PROVIDER #140172

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for Medicare patients treated in our facilities during 1986.

The data published is for Chicago Osteopathic Medical Centers, an organization with two facilities, an inner-city hospital in Chicago and a suburban hospital in Olympia Fields, Illinois. COMC is a member of the Chicago Osteopathic Health Systems and affiliated with the Chicago College of Osteopathic Medicine. Both COMC hospitals are full service teaching centers that provide for all of the specialty and sub-specialty medical services with the exception of organ transplantation.

COMC has a single medical staff. It conducts an intensive review of the medical care provided to every patient who expires at our facilities. Mortality review is part of our continuous and on-going peer review process which is applied to all of the medical services we provide, and is an integral part of our Quality Assurance program. In addition, we are accredited by the American Osteopathic Association and has received its highest commendation for our Quality Assurance and Peer Review programs.

The specific mortality data reported by the Health Care Financing Administration (HCFA) for COMC has been carefully reviewed by the Mortality Review Committee of the medical staff, physician chairmen of the departments of medicine and surgery, by the physician representatives of the Quality Assurance Committee of the medical staff, and by medical center administration. In each case, the expiration of the patient was deemed non-preventable. It should also be noted that:

- Of the sixteen diagnostic categories used by HCFA we were reported to have only one high risk category, gastrointestinal catastrophies, which was in excess of predicted mortality rates.

- A review of our records indicate that 55 cases of gastrointestinal catastrophies were discharged from COMC for calendar year 1986. There were no additional deaths in this population.

  Since this number exceeds the 34 discharges listed in the HCFA data our actual mortality rate for this diagnostic category falls well within the range of predicted mortalities.

Of the 13 patients who died:

- Five patients were placed on "No Code" by family request.

- Seven patients were over the age of 80.

- Six patients suffered from end stage renal and/or liver disease.

- All of the patients had serious concomitant medical conditions, including carcinoma and multiple organ failure.

We will be pleased to verify our data with you.

Thank you for the opportunity to present this response. If you have any questions, please feel free to call.

Sincerely,

Lawrence U. Haspel, D.O.

Lawrence U. Haspel, D.O.
Executive Vice President

LUH:gdw

0596N

Evangelical Health Systems

Christ Hospital & Medical Center
4440 West 95th Street, Oak Lawn, Illinois 60453 (312) 425-8000

HCFA DATA ANALYSIS

CHRIST HOSPITAL welcomes the opportunity to respond to the recently published HCFA mortality data. Christ Hospital's actual mortality rates did not fall outside the predicted ranges for any diagnostic categories. However, because we feel that mortality data can be appropriately used to guide or focus medical peer review, Christ Hospital elected to analyze categories where it appeared that the actual rate ranked higher than average in the predicted ranges.

After medical peer review, it was confirmed that the HCFA methodology was not able to account for several characteristics which contributed to the actual cause of death.

For example, Christ Hospital and Medical Center is a large community teaching institution which receives a significant number of cancer patients who are referred for specialized oncology services. Many of these patients are in end-stage disease and palliative treatment is the indicated service. In analyzing the mortality data, it was determined that almost the entire population of patients who succumbed at Christ Hospital were end-stage terminal patients with multi-system metastatic disease.

In the urologic and pulmonary disease categories, the majority of cases involved patients with documented terminal disease who were transferred from nursing homes. In addition, current mandated coding regulations stipulate that the assignment of the principal diagnosis be based on the patient's primary reason for admission to the hospital. In most cases, the principal diagnosis was not the cause of death. The cause of death was attributed to the patient's acute underlying co-morbid conditions such as acute renal failure, respiratory failure, septic shock, acute myocardial infarction, cerebrovascular accident, pulmonary embolism, and ruptured abdominal aortic aneurysm. The HCFA methodology did not allow for conditions other than chronic co-morbidities. Thus, the factors which caused the actual mortality rate to fall into the upper end of the predicted range were patient-specific characteristics which may Christ Hospital's admissions differ significantly from the "average" patient reflected in the HCFA data.

Christ Hospital acknowledges the value of using mortality statistics as a mechanism with which to screen clinical data and identify areas which warrant a more in-depth focussed review. However, as stated by the JCAH and AHA, Christ Hospital is aware that statistical indicators are not direct measures of quality; and as demonstrated by the above analysis, any determination about actual quality of patient care can only be made as part of a case-oriented medical peer review process.

618/662-2131

CLAY
COUNTY
HOSPITAL
700 North Mill
Flora, Illinois 62839

October 12, 1987

Department of Health & Human Services
Health Care Financing Administration
Washington D.C.

RE: Hospital - 140016

On behalf of Clay County Hospital, I would like to take this opportunity to comment on the publication of selected mortality data of Medicare patients. As an overview, HCFA views the disclosure of this patient outcome data as part of an extensive quality review initiative. We share with enthusiasm the necessity for intensive quality review in hospitals and of related healthcare providers, but are very concerned about the ill-advised release of this particular set of data. It isrecognized by all concerned, including HCFA, that the methodogy of the model used for compiling the mortality data is fraught with fundamental errors and has not been validated. Indeed, this mortality rate information viewed in isolation supports no conclusions relative to quality of care, and very well may lead to unfortunate and inaccurate conclusions being drawn.

Upon review of the data specific to Clay County Hospital, I offer the following comments:

1. The average age of the Medicare patients who died was 82.1 years. This is contrasted to the average life expectancy for males of 72.5 years, and females of 78 years.

2. Eight out of the total fifty-two listed mortalities occured after the patient was dischared from the hospital and may be entirely unrelated to the condition of the patient at the time of dischare. Assuming the deaths were unrelated, 15% of the data becomes erroneous, and the hospital's overall mortality rate falls to 17%.

3. In five of the sixteen specific disease categories or medical conditions, the hospital experienced an actual mortality rate of 0%.

4. In the diagnostic category of "cancer", the hospital's actual mortality rate is reported as 64%, with a "Range of Predicted Mortality" of 10% to 61%. Most of these mortality cases had multiple admissions to health care facilities during 1986 for treatment or therapy of the

disease, and in each case their last admission was necessitated due to medical problems associated with the terminal stage of the illness. Since our community has no access to "hospice" type services, it is common practice for patients to look to the hospital for terminal care.

In closing, I would like to reiterate our belief that quality of care activities are a top priority for the hospital and it's various publics. The aforementioned data, viewed in isolation and unvalidated as a statistical model, do not measure hospital performance. The data, when validated, can be useful and should be used to help focus hospital quality assurance activities but not as the basis for judging the quality of care rendered by a particular institution.

Thank you for allowing these comments.

Sincerely,

John E Monnahan

John E. Monnahan
Administrator

JEM/sh

COLUMBUS - CUNEO - CABRINI MEDICAL CENTER
COLUMBUS • CABRINI MEDICAL STAFF

2520 North Lakeview Avenue • Chicago, Illinois 60614 • 312/883-6781

October 23, 1987

William L. Roper, M.D.
Administrator
Dept. of Health & Human Services
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

The Governing Board and Medical Staff of Columbus Hospital are committed to providing the highest level of quality care to all our patients and would like to make the following statement in regards to the release of the HCFA Mortality Data. Quality care can only be effectively evaluated through the process of peer review which includes as part of this process all our hospital deaths. After careful review of the data provided us we noted that our Pulmonary Disease Category was over the predicted range by 1%. Upon further investigation, we noted the following information:

1. 66% of the cases were over the age of 80.
2. Over 60% of the cases had other complicating underlying disease, such as Cancer, End-stage Renal Disease, End-stage Heart Failure.
3. Over 50% of the cases were from nursing homes.
4. 9% of the cases died within 30 days of discharge.

In summary, we would like to say that the data released does not truly reflect the multiple medical problems of the Medicare patients. The data is insufficient to draw any conclusions regarding the quality of care at our institution.

Sincerely yours,

James F. Chambliss, M.D.
Executive Medical Director

JFC/jb

Community Hospital of Ottawa
1100 East Norris Drive
Ottawa, Illinois 61350
815-433-3100



October 6, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Sir:

Re: Hospital ID #140110
Community Hospital of Ottawa
Ottawa, IL 61350

In response to the information submitted on September 21, 1987, relative to the selected mortality information on all short term care hospitals which treated Medicare patients in 1986, the information relative to the above-cited hospital is not accurate.

The report indicates total Medicare admissions during that study period of 945; however, the actual number should be 1,491, or a difference of 546 additional admissions. There were also six (6) additional deaths during 1986 that were not listed. With a recalculation, you will quickly note that the percentage of death goes down dramatically with the inclusion of all the admissions for that particular period.

I trust you will adjust your records accordingly.

Sincerely,

Yale M. Wolk, President &
Chief Executive Officer

YMW:iw

The Medical Center of Lake County

900 Garfield Avenue Libertyville, Illinois 60048-3199 Telephone 312/362-2900

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Enclosed are our comments concerning the HCFA Mortality Data to be released in December of this year.

Thank you for allowing us an opportunity to comment prior to the release of this data.

Yours very truly,

Lawrence Swanson
Vice President-Finance

LS:mb

Enclosure

COMMENTS ON THE HCFA MORTALITY DATA
CONDELL MEMORIAL HOSPITAL

In all of the diagnostic categories, the Hospital's actual mortality rate falls within the range of the predicted mortality rate.

We have only verified the data for those patients that actually died while they were in the Hospital. We have not verified any deaths which supposedly occurred after discharge; therefore, we cannot say if those deaths were related to the patient's condition during the last hospitalization or if the death resulted from some unrelated condition.

Even though our actual mortality rates fall within the predicted ranges, these data are not indicative of the Hospital's performance as mortality rates can vary for many valid reasons. Each case needs to be reviewed individually in order to judge the quality of care provided by this Hospital or any hospital. Standards of quality care should be determined on the outcome of the case in conjunction with the course of treatment.

Cook County Hospital
1835 W. Harrison St., Chicago, Illinois 60612-9985

October 15, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human
Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

On behalf of Cook County Hospital, I wish to extend my gratitude to the Health Care Financing Administration for the opportunity to comment on the mortality statistics for this institution.

It is certainly gratifying to note that overall mortality for Medicare patients treated at Cook County Hospital is at the lowest range predicted. The data indicates that in no single diagnostic category does our mortality rate exceed the predicated rates, and in three (3) situations, our mortality rates are below predicted values. In addition, in two (2) categories our mortality rates are 0%.

Cook County Hospital is exceptionally proud of these statistics because this institution treats an entirely different patient population than the vast majority of hospitals in this country. The residents of the community within the Hospital's primary service areas are severely distressed according to socio-economic measures analyzed. The patients utilizing the City of Chicago's only public general hospital tend to have more serious and complex health conditions than other institutions in this city.

In addition, Cook County Hospital has been designated by the Chicago Department of Health as one of seven (7) Level I Trauma Centers in the City of Chicago. Because of this designation Cook County Hospital cares for the most critically injured patients. Therefore, in analyzing and comparing mortality statistics in Trauma, one must recognize that Cook County Hospital and other Level I Trauma Centers treat the most seriously injured trauma patients within the metropolitan area. Cook County Hospital also is one of the three (3) functioning burn units within the metropolitan Chicago area.

Cook County Hospital internal quality assurance reviews also indicate low mortality rates for this institution. I would like to point out that in analyzing the Federal Governments data in the

lower risk categories, the vast majority of these patients were also afflicted with many co-existing conditions such as cancer and severe heart disease. Because of the manner in which the Federal Government mandates the data be provided for billing purposes, these additional serious diagnoses are not made available per these statistics. In addition, many patients who were discharged and died within thirty (30) days following their hospitalization were patients in a terminal stage of their disease who preferred to be with their families and friends.

I would like to note the following three (3) errors identified in our analysis of the data:

PATIENT ID #	SURNAME	DATE OF DEATH PER HCFA RECORDS	DATE OF DEATH PER HOSPITAL RECORDS
[redacted]	[redacted]	12/26/86	10/25/86
[redacted]	[redacted]	1/31/86	1/29/86
[redacted]	[redacted]	12/31/86	12/19/86

As per the instructions received from HCFA, Cook County Hospital is unable to verify any information regarding a patient's death that did not occur at this institution.

Again, I appreciate the opportunity to comment on these statistics.

Sincerely,

Terrence M. Hansen
Hospital Director
Medicare Provider #14-0124

TMH/seg

CRAWFORD MEMORIAL HOSPITAL

October 21, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Crawford Memorial Hospital would like to emphasize the concerns expressed by Illinois Hospital Administrators concerning the Health Care Financing Administrations information of hospital mortality rate:

1. The use of a 30 day post-admission mortality rate will attribute to the Hospital deaths that are unrelated to the condition of the patient that was under treatment at time of discharge.

2. The using of the last admission, the sample of cases examined is biased toward those resulting in death which will overestimate the probability of a Hospital stay resulting in death.

3. No allowance has been made for severity of illness within diagnosis or number of patients.

4. The report circumvents the peer review process.

5. Statistical analysis of mortality rates do not measure quality of care.

Thank you for your consideration.

Sincerely,

Barbara Miller

Barbara Miller
Quality Assurance Coordinator

Health/Care - Q.A.
1000 North Allen Street • Robinson, Illinois 62454 • Phone (618) 544-3131

A National Healthcare Facility

Crossroads Community Hospital
#8 Doctors Park
Mt. Vernon, Illinois 62864
618/244-5500

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D. C. 20201

Dear Mr. Roper: Re: Comments Regarding Mortality Statistics Published on Crossroads Community Hospital

As requested in your letter dated September 21, 1987, we have thoroughly reviewed the mortality information compiled by HCFA on Medicare patients admitted to our facility during 1986. Following review of this information, we were able to verify the accuracy of the final data scheduled for publication, however, we would like to add our comments regarding certain aspects of this project.

1. DIAGNOSTIC CATEGORY - We would like to point out that the cause of death of patients who have expired in our hospital are not always directly related to the "Primary Diagnosis" shown on the admission paperwork. This could lead to misinterpretation of the data provided and skew the statistics compiled by HCFA.

2. RANGE OF PREDICTED MORTALITY RATES - We were somewhat confused as to the actual meaning of this column. The range appears to be extremely broad - "0 - 100%" - in some diagnostic categories, and we are not certain as to how that would affect the interpretation of our actual mortality rates in those categories. We would assume that an actual mortality rate that falls within the predictable range indicates that we are within acceptable ranges and limits for those categories. If this is <u>not</u> the case, we would appreciate the clarification on that issue.

3. GENERAL COMMENTS - Without burdening you with all of the rhetoric have probably already heard regarding the accuracy and/or usefulness of this data, we would like to add our name to the list of institutions objecting to the publication of this data for the following general reasons:

   A. Mortality rates vary based upon the types of patients seen by any institution and cannot, therefore, be used as an accurate measure of quality of care.

   B. Due to the small size and number of admissions of some hospitals, the data can be skewed disproportionately as a result of smaller populations of patients served.

C. The statistics do not recognize that many deaths occur following transfer of a patient to a hospital from nursing homes or following emergency admissions. Therefore, hospitals who serve as tertiary care institutions will sometimes show higher mortality rates. This same problem occurs when a Medicare patient is treated by more than one hospital during the 30 days preceding death.

D. While we can understand the release of some statistics under the Freedom of Information Act, we do not think this data can be accurately perceived by the general public. Such data is far more useful to health care statisticians and other experts and more than likely will be misinterpreted by lay people who react only to the statistics and not the underlying factors.

E. If this data is truly useful to the public and private hospital, then we feel the same data should be released for government controlled and V.A. hospitals. This is one area where a dual standard cannot and should not be permitted.

We trust our comments meet with your approval.

Sincerely,

CROSSROADS COMMUNITY HOSPITAL

Ron Wolff
Administrator

RW.mlc

cc: Dr. Gerald Fox
Executive Committee

Decatur Memorial Hospital
2300 N. Edward St., Decatur, IL 62526
217/877-8121

October 27, 1987

Harvey Brook
Health Standards & Quality Bureau
2D2 Meadow C Building
6300 Security Boulevard
Baltimore, Maryland 21207

Dear Mr. Brook:

Regarding the Health Care Financing Administration's (HCFA) planned release of mortality information for Medicare patients during 1986, Decatur Memorial Hospital would like to respond with the following information and ask that it be included in the public record.

Decatur Memorial Hospital (DMH) is a 313 bed acute care hospital which also operates a 54 bed long term care unit.

As a not-for-profit organization founded on the premise of community need, DMH has a 71 year tradition of caring for not only the normal and routine health care needs of the community but also the special and severe causes of mortality for the region. This is evidenced in the HCFA data in that cancer, gastrointestinal disease and pulmonary disease represent 28% of your recorded Medicare cases. And, cancer and heart disease, the two leading causes of death, account for 24% of those Medicare cases in the mortality report.

Although DMH does not question the predicted mortality ranges (we acknowledge the complex statistical methodology utilized to develop this model and the special data points not readily available to other organizations for comparative purposes), the total base number of cases does not coincide with hospital records. DMH files indicate that 4,401 Medicare beneficiaries were provided service at DMH in 1986, while the HCFA report shows only 2,679.

Certainly, the inclusion of an additional 1,722 cases could impact Decatur Memorial Hospital's "actual mortality rate," and possibly the "range of predicted mortality rates" included in our report. Additionally, it can not be assumed that those additional 1,722 cases would be distributed statistically consistently

Decatur Memorial Hospital
2300 N. Edward St., Decatur, IL 62526
217/877-8121

with the case categories included in the report. We believe the report, as it applies to Decatur Memorial Hospital, may be significantly compromised in its statistical validity as a result of these omissions.

Finally, mortality rates are only one component of the intricate mosaic that makes up "quality health care." As a JCAH accredited institution, DMH employs an active QA/UR process which daily works to comply with the JCAH standards specified in the accreditation manual, "The utilization review program shall endeavor to assure appropriate allocation of the hospital's resources in striving to provide high quality patient care in the most cost effective manner. The utilization program shall address over-utilization, under-utilization, and inefficient scheduling of resources." Today's technology places many more procedures in the outpatient arena -- procedures that would only a few years ago have taken place in the hospital. Therefore, in viewing "inpatient" mortality data, the public should be cautioned to consider the information in the context that, more and more, today's <u>average</u> hospital patient is far sicker than in the past.

Decatur Memorial Hospital appreciates these initial steps being taken by HCFA to assist us in our endeavor to both better measure and provide the highest quality health care possible to all of our patients. As the parameters of this study become more finely tuned in future editions, and are combined with quality indicators determined both by other organizations and by the hospitals themselves, we believe both consumers and the health care providers themselves will benefit.

Sincerely,

Donald I. Gent
President & CEO

DG:cdc

cc: Dr. William L. Roper

DOUGLAS JARMAN

October 16, 1987

Health Care Financing Administration
Health Standard and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

In response to the proposed presentation of selected mortality data to the public, we would like to submit the following comments, even though our hospital statistics are within the limits of your "predicted range".

Of the forty-seven patients presented, five expired post-discharge. Those of which we were able to trace had a cause of death unrelated to their principal diagnosis during their most recent hospitalization. Twenty of the remaining forty-two patients had a cause of death, as recorded by the attending physician on the patient's medical record, that did not agree with the principal diagnosis for their hospitalization, i.e. a patient was admitted with a diagnosis of pneumonia and the cause of death was an acute onset of V-tachycardia with subsequent possible myocardial infarction.

It appears that your methodology and selected criteria which resulted in your mortality data over emphasizes a death that a hospital has no control of post discharge and an inpatient cause of death unrelated to the principal diagnosis for the patient's hospitalization. Thus, the usefulness of this data to the general public is questionable and in our opinion is not representative of our actual mortality rate based on principal diagnosis, which we feel is much lower for all patient classes including Medicare than is presented by your statistical analysis.

Sincerely,

Mark F. Fedyk
Administrator

DOUGLAS COUNTY JARMAN MEMORIAL HOSPITAL

704 North Main Street • Tuscola, Illinois 61953 • 217/253-3361

EDWARD HOSPITAL
Sharing responsibility for your family's health

801 South Washington Street
Naperville, Illinois 60566

Telephone:
312/355-0450

October 28, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Comments from Edward Hospital - Medicare Provider #140231

Dear Dr. Roper,

I am responding on behalf of Edward Hospital to the data provided to us describing mortality experience.

First, we believe the fundamental responsibility of focusing attention through the provision of relevant data on the quality of medical care services is sound. We believe that this responsibility should optimally be shared by appropriate government agencies and those actually providing medical care services. In so doing, we can best assure that data which are relevant to the question, consistent in methodology, reliable and valid, and most importantly, capable of being understood in a context that permits differentiation are provided.

In the instance of Edward Hospital, this data release currently under examination indicates that the mortality experience in all categories fell within predicted ranges. While it is satisfying to see positive performance, we are concerned that current methodology for reporting these data still has numerous inadequacies.

Rather than exhaustively detail our concerns regarding the inadequacies of current data methodology, I will leave that to others who I know are more technically qualified. Suffice to say, as we understand the current system, the data are gathered, analyzed and reported on the assumption that there are no variables which could influence the actual mortality experience of one hospital versus another. Even rudimentary knowledge on this subject results in the clear conclusion that there are many variables which can impact the mortality experience for the same diagnosis from one hospital to the next and that such differences in final outcome do not in any way indicate a difference in the quality of the service associated with that diagnosis.

In order to be constructive toward the goal of ever better quality care, the future analysis and reporting of mortality data must address these variables in order for anyone to realize the benefits theoretically available to us.

From our own internal vantage point, we have been using one of the most sophisticated and comprehensive quality assurance data systems available and we are confident that with or without government mortality data, we apply great effort to assure the highest quality care. To the extent that government mortality data can be further refined, it can only help our cause.

We thank you for your attention to our comments and trust that your efforts will be directed toward improving what is now an elementary and inadequate system which nevertheless has good intention and promise for the future.

Sincerely,

John R. Whitcomb
President

JRW/dt

Elmhurst Memorial Hospital

COMMENTS ON THE HCFA MORTALITY DATA
Provider Number 140200
Submitted: Monday, October 26, 1987

Introduction

Elmhurst Memorial Hospital is pleased to note that it has been identified as being well within normal mortality ranges nationwide for the sixteen disease clusters defined by HCFA. This comes as no surprise to an institution that prides itself in providing services to the older adult population.

Response to Presentation of Data

Elmhurst Memorial Hospital is committed to caring for the entire family. As a community hospital, that commitment is evident in the range of services and quality of care provided to area residents. Mortality data, such as that released by HCFA, provides a less than complete view and perhaps misleading sense of the nature of the institution presented.

Medicare patients comprised approximately 27 percent of the total inpatient care rendered by Elmhurst Memorial Hospital during 1986. The hospital finds itself serving a population that is maturing in a manner consistent with national demographics.

Services for older adults are increasing in scope and breadth each year. Similarly, the care provided to older adults and our ability to identify and respond to the special needs of this population attracts patients to Elmhurst Memorial Hospital.

Review of Specific Statistics

During the calendar year 1986, Elmhurst Memorial Hospital provided care to 4,832 Medicare inpatients. Of that number, 394 died. Of the 394 deaths, 67 (or 17 percent) occurred during the 30 days after discharge identified by HCFA in its data.

The average age of the 394 patients who died was 77.7 years. The average age of the 67 who died after leaving the hospital was higher, 78.5 years. Of the 67, 32 were males (average age 79.3 years) and 35 were females (average 77.9 years).

Upon review of the medical records, the circumstances relating to each of the 67 30-day post-discharge deaths provide valuable insight into the patients' conditions.

200 Berteau Avenue, Elmhurst, Illinois 60126 312/833-1400

1. 65 individuals or 97 percent of the total deaths after discharge had a chronic underlying disease process (comorbid condition). Only 2 individuals or 3 percent did not have a chronic disease process.

2. 46 individuals or 68.7 percent of the total deaths after discharge were patients who went directly from the hospital to nursing homes for care.

3. 25 of the total deaths after discharge or 37.3 percent could be defined as "expected outcome." In non-medical terms these patients were released to return to their families and homes with the possibility of death in the near future.

4. Of particular interest is the fact that 18 or 26.9 percent of the total deaths after discharge were individuals/patients who had experienced multiple admissions during 1986.

Issues for Consideration

Not at issue are the data as presented by HCFA. At issue is the inability of such data to present a complete picture of quality and acuity for Elmhurst Memorial Hospital and its patients. It is simply not clinically valid to assume a study of Medicare patients provides a representative sampling of the hospital as a whole.

Quality is an intangible commodity. It is not easily measured; it is certainly not something that can be packaged. Throughout the hospital, quality is being assessed on a regular basis, at the individual patient level, through the peer review process--physicians reviewing physicians. This type of review provides multifaceted data: severity of illness, appropriateness of treatment, sequence of events, disease process, outcome, etc., to measure quality of care which we at Elmhurst Memorial Hospital believe is very important.

Commitment to Excellence

Elmhurst Memorial Hospital has identified its services and care for the elderly as an area of excellence. A full time Geriatric Educational Specialist focuses her attention on promoting nursing and medical staff awareness of the special needs of the elderly. Continuing medical education for physicians on staff frequently includes programs to address needs of older adults.

Our commitment to older adults also is evident in educational programs presented in locations where they gather, throughout DuPage County. Such programs explore issues such as Alzheimer's Disease, caring for a chronically ill partner, older adult nutritional needs, remaining physically fit, and much more.

Continuity of Care

Also a concern addressed by the hospital and its affiliate organizations is the need for continuity of care. Our commitment to continuity can be seen in our home health care services. Elmhurst Memorial Home Health Care provides the quality of care and scope of services to enable patients to return to their families and homes sooner.

Home health services include everything from care by a registered nurse to light homemaking help, in-home rehabilitation services to durable medical equipment rental. The program has grown out of identified needs.

Recognizing the needs of those who are more acutely ill, Elmhurst Memorial Hospital has put into motion plans to develop an extended care facility that will offer the same high quality care that patients receive in our hospital.

Understanding the Needs of the Terminally Ill

Elmhurst Memorial Hospital's understanding of the unique needs of the terminally ill can be seen in its supportive relationship to Hospice of DuPage. And, it can be seen in its active oncology program, which provides a wide spectrum of services to cancer patients.

By attracting a larger than normal number of chronic dialysis, terminally ill and cancer patients, the hospital's acuity level increases as does the number of patients who may be expected to die a short time after discharge...which may not be evident given the method of HCFA's presentation of data.

Inherent to chronic disease or illness are the risks and likelihood of increased mortality rates within the total body of patients treated. Recognizing these factors, does higher mortality suggest a lesser quality? Or does it suggest a willingness, or aggressive positioning on the part of an institution, to provide services which may not be offered by other institutions?

Closing Statement

While Elmhurst Memorial Hospital was identified as being well within the HCFA mortality ranges nationwide, the real issue remains how to identify for the health care consumer--the patient and patient's family--what the data really means.

Measuring overall hospital performance or quality on the basis of a sampling of older adults is simply not an appropriate basis for assessment. The health care consumer needs to recognize the intangible commodities of service, compassion, trust, and the relationship between physician and patient when making a choice for medical treatment.

Data Corrections

Only one correction was identified from the data provided by HCFA. Using only the patient code number, it is as follows:

[redacted].....GI
Admission date should read.....12/25/86
Discharge Date.....01/01/87
DOD should be.....01/01/87
Principal diagnosis.....228.04
Principal procedure.....44.13

The Evanston Hospital
Owned and Operated by the
Evanston Hospital Corporation

2650 Ridge Avenue
Evanston, Illinois 60201
312 492 2000

Office of the Senior Vice President
312 492 3964

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: Mortality Data
Medicare Provider Number: 14-0010

Dear Dr. Roper:

Overall, The Evanston Hospital Corporation's mortality data is very favorable. However, we feel that it is very important to recognize that mortality data is only one quality of care indicator that is monitored at The Evanston Hospital Corporation. There are 13 other indicators which include the following:

- Hospital Acquired Infection Rate
- Hospital Acquired Surgical Wound Infection Rate
- Clean Wound Infection Rate
- Hospital Acquired Nursery Infection Rate
- Autopsy Rate
- Transfusion Reaction Rate
- Newborn Mortality Rate
- Anesthesia Mortality Rate
- Medication Error Rate
- Maternal Mortality Rate
- Radiology Retake Rate
- Cesarean Section Rate
- Skin Breakdown Rate

Applicable national standards for each of these measures of quality were adopted from prestigious medical agencies, medical institutions, and physicians. Each Clinical Department (i.e., Medicine, Surgery) generates a monthly report on the outcomes of care provided in their respective areas. Information on these monthly quality of care indices and activities are summarized at Board of Directors meetings. Together, the outcomes of these

monitoring activities, along with Medicare mortality data, would provide a much more balanced view and meaningful understanding of the level of the quality of care provided at our Hospitals. In July, 1987, our Quality Assurance monitoring activities were reviewed and found to be impressive by the Joint Commission on Health Care Organizations.

A more microscopic view of the HCFA mortality data for The Evanston and Glenbrook Hospitals reveals that 113 of the 436 Medicare deaths occurred after discharge from our facility. The cause of these deaths may or may not have been related to the condition under treatment at the time of the patient's discharge.

Our internal data indicates that there was a total of 497 deaths at our facilities for the time period of October 1, 1986 through August 31, 1987 against 22,709 admissions. A comparison of our Medicare deaths to all deaths measured against all admissions would produce a lower overall mortality rate. Conversely, by using only the last admission, the sample of cases presented by HCFA is biased towards those resulting in death which would overstate the probability of having a hospital stay result in death.

Through our Quality Assurance monitoring activities, we have learned that a meaningful understanding of the level of the quality of care cannot be digested knowledgeably by examining raw data without the aid of documentary and interpretive information. It is important for consumers to recognize that severity of illness, along with community and institutional demographics, all play a part in contributing to patient mix. Consequently, the HCFA difference between predicted and actual performance may not offer an appropriate reflection of the Hospital's performance. While the HCFA data viewed in isolation is not a comprehensive barometer of performance, the data can play a useful role in helping hospitals structure the direction of their Quality Assurance activities.

Sincerely yours,

Raymond Grady
Senior Vice President

RG:alm

FOSTER G. McGAW HOSPITAL
LOYOLA UNIVERSITY OF CHICAGO
2160 South First Avenue, Maywood, Illinois 60153 312 531-3000

October 23, 1987

William L. Roper,M.D.
Administrator, Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Dear Dr. Roper:

Foster G. McGaw Hospital of Loyola University of Chicago has received the Health Care Financing Administration (HCFA) selected mortality data for Medicare patients treated in 1986. We have analyzed this information to the best of our capability, and have prepared the attached response to be published in conjunction with your release of this information in December 1987.

As you suggested in your cover letter of September 21, 1987, we have kept our response as concise as possible. Obviously, discussion of a subject as significant and complex as the calculation and interpretation of this type of mortality data is subject to extensive discussion. Either myself, or other representatives from Loyola University Medical Center, would be happy to contribute to a more intensive discussion on this subject, if your department were to initiate such a forum.

Please let me know if we can provide you with any further input on this subject.

Sincerely,

Robert S. Condry, FACHE
Director, Foster G. McGaw Hospital
Loyola University of Chicago

RSC:cb

attachment

FOSTER G. McGAW HOSPITAL
LOYOLA UNIVERSITY OF CHICAGO
2160 South First Avenue, Maywood, Illinois 60153 312 531-3000

Medicare Provider Number 14-0276

Response to Health Care Financing Administration
Selected Mortality Data
Calendar Year 1986

The selected mortality statistics produced by the Health Care Financing Administration (HCFA) are consistent with other indicators in substantiating the high quality of care provided at Foster G. McGaw Hospital of Loyola University of Chicago. The extremely low overall mortality rate, as published by HCFA, is especially remarkable in light of the fact that Foster G. McGaw Hospital treats one of the most severely ill mix of Medicare patients in the nation.

The HCFA data indicates a uniquely consistent high level of care in each of the 16 selected diagnostic categories. Foster G. McGaw Hospital's actual mortality rates were well within HCFA predicted ranges for each category, and were at or below the median expected range for all but 3 of the 16 diagnostic groups. This implies a strong consistency in the care provided in all disciplines.

Foster G. McGaw Hospital's excellence is especially notable in view of the severely ill patients that are treated at the hospital. HCFA data published in the Federal Register presents Foster G. McGaw Hospital's Medicare patient case mix index of 1.79 as one of the highest in the nation (highest Medicare case mix within the State of Illinois; the third highest mix of university-owned teaching hospitals in the United States; and the thirteenth most complex case mix of <u>all</u> hospitals in the nation). Review of the HCFA mortality data in light of this extremely ill patient population reflects an unparalleled dedication and success in patient care.

While analysis of the HCFA mortality data is supportive of other indicators of the high quality care provided at Foster G. McGaw Hospital, review of these data suggests that the methodology used by HCFA produces rates that are negatively skewed. The use of only final admissions in this calculation most seriously affects facilities that direct significant resources toward long-term treatment of terminal patients. Foster G. McGaw Hospital's designation as a Comprehensive Cancer Center falls within this category, and hence, results in higher mortality rates for cancer, sepsis, and gastrointestinal diseases than would be experienced at other institutions. The HCFA calculations do not fully adjust for this type of selected patient population.

Another shortcoming of the HCFA methodology that tends to exaggerate the hospital mortality rates is a limited adjustment for complicating health factors, previous admissions, and patients transferred from other institutions. This most notably affects major tertiary care institutions, such as Foster G. McGaw Hospital, where a large portion of the patient population consists of patients that are too ill to be treated at community hospitals. Hence, the condition of the patient upon admission is frequently quite critical, which tends to inflate mortality calculations. Furthermore, no adjustment is made for patients who are admitted through the Emergency Room (frequently in critical condition). This is another factor that increases the mortality rates published for Foster G. McGaw Hospital, due to our designation as a regional Level I Trauma Center.

In summary, Foster G. McGaw Hospital is pleased that the HCFA data substantiates the high quality of care provided at our institution. While we believe that the methodology used by HCFA tends to exaggerate the actual mortality rates, comparison of these figures with expected ranges and with other institutions supports other indices of an overall high level of care and a consistent application of quality care principals across medical disciplines. Still, we cannot support the contention that mortality data alone is an indicator of quality care. We contend that mortality data must be considered in perspective with peer review and other, more comprehensive, quality review factors. The extremely critical and complex nature of the patients treated at Foster G. McGaw Hospital; the dedication of the institution to treatment of a number of chronic, and potentially terminal, disease entities; the designation of the institution as a regional trauma center; and the unusually high number of patients transferred into this tertiary care institution all make the achievement of Foster G. McGaw Hospital's low mortality rates even more remarkable.

COMMENTS ON THE HCFA MORTALITY DATA

FRANCISCAN MEDICAL CENTER
ROCK ISLAND, ILLINOIS
MEDICARE PROVIDER NUMBER 140280

INTERPRETIVE REMARKS

In the diagnostic category, sepsis, the hospital's actual mortality data as released by HCFA, falls outside of the range of the predicted mortality rate. Several factors may account for this difference.

Per HCFA, ten of sixteen patients died at their last hospital admission or within 30 days of that admission at Franciscan because of sepsis.

1. One of the patients, [redacted] was discharged with no symptoms of infection present, but died of a myocardial infarction 21 days later in the nursing home. His death was not a result of sepsis and should not fall in the category of sepsis. This changes the hospital mortality rate for sepsis to 56%, within HCFA's range of predicted mortality rates.

2. Five patients were admitted to the hospital from nursing homes with a septic condition already present. Two of these five patients died within 24 hours of admission to the hospital, [redacted] and [redacted] due to the severity of the infection, their advanced age and other comorbidities.

3. For nine of the ten patients, excluding [redacted], death was the expected outcome, due to their advanced age and comorbidities. The youngest patient was 72 years old, admitted from a nursing home, and the others ranged from 78 to 95 years of age. The comorbidities included cancer, renal failure, congestive heart disease and diabetes.

Michael A. Turner
Executive Vice President

CAS:dg
10/26/87

FRANKLIN BOULEVARD COMMUNITY HOSPITAL
3240 W. Franklin Blvd., Chicago, Illinois 60624

HOSPITAL ID NUMBER = 140151

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

This is with regards to two Medicare patients treated in our facility in 1986:

(1) [redacted] - 73 year old female admitted on 01-24-86 via Emergency Room brought in by paramedics because of severe dehydration, weakness, chills and fever. Patient is a known case of diabetes mellitus, coronary artery disease and chronic congestive heart failure. Impression on admission was severe electrolyte disturbance, hypertension, diabetes mellitus and Parkinsonism. Patient lost 20 lbs in two weeks and is unable to tolerate any oral feedings. Barium enema findings were consistent with severe adynamic ileus. Condition continued to deteriorate, placed on supportive therapy, and consultation obtained. Urine culture showed E. coli, treated with Cleocin and Gentamycin. Patient expired on 10th hospital day.

(2) [redacted] - 67 year old female admitted on 12-14-86 because of severe dehydration secondary to terminal cancer (squamous cell carcinoma of the cervix with metastasis to the liver and omentum). Patient was treated symptomatically in the hospital with IV fluids and parenteral analgesics. The electrolyte imbalance was corrected gradually and the patient started to tolerate soft diet. She was subsequently discharged on 12-23-86 pain-free, more alert, fully hydrated and was instructed to continue home health care management and was to report to the office after a week for follow-up. This patient was not at our facility at the time of her death.

This is our comment on the mortality as indicated in your report.

Yours truly,

Norma Hepkin

Norma M. Hepkin
Assistant Administrator

Freeport Memorial Hospital

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Freeport Memorial Hospital in Freeport, Illinois has received the mortality information that you have sent to us. On behalf of the governing board, administration, management, and the medical staff of Freeport Memorial Hospital, I would like to respond to this information.

Freeport Memorial Hospital is a 183-bed not-for-profit hospital offering a range of services including Medicine, Surgery, Pediatrics, Obstetrics, Gynecology, and many sub-specialties within these general areas. Approximately 84% of the active medical staff is board eligible or board certified in respect to these specialties.

Freeport Memorial Hospital is a rural hospital which has the distinction of being a Rural Referral Center. We are one of the four hospitals so designated in the state of Illinois.

The population mix that Freeport Memorial serves is an elderly one, because of this we see a greater complexity of Medicare cases. Medicare patients comprise 38% of hospital admissions. Approximately 34% of our total admissions come through the emergency room as we are a designated trauma center. We also have a hospital-based Skilled Nursing Facility which provides further care, after hospitalization, to our patients needing skilled services.

As part of our mission, we provide care to all patients, regardless of their ability to pay.

The hospital supports a very active case management system which includes Quality Assurance, Utilization Review and Risk Management. The Quality Assurance activities are coordinated throughout every department and service area of the hospital.

The hospital has a Quality Coordinating Council which is a strong committee of medical staff and hospital staff which reviews activities of hospital departments and services. Our medical staff has established

1045 WEST STEPHENSON STREET • FREEPORT, ILLINOIS 61032 • 815/235-4131

monitors, with appropriate criteria, to review quality of care concerns and set action when appropriate. Mortality review is one of the current monitors that our medical staff departments review, on an on-going basis, using established criteria. Appropriate action is taken on each case that does not meet criteria.

Freeport Memorial Hospital is a fully accredited hospital by the Joint Commission of Healthcare Organizations. The last review was in May of 1985 at which time the hospital received the maximum full three-year accreditation.

The hospital has reviewed the mortality data which you have provided us. We will be able to use this information to help focus quality assurance activities as we feel it cannot be the sole basis for judging quality of care rendered by a particular institution. Mortality is only one of the many quality indicators used by Freeport Memorial in their quality assurance program. To truly assess the hospital's performance requires evaluation of more than the mortality data alone.

We have referred this report to the Quality Coordinating Council for their use as a retrospective tool. Our hospital is constantly upgrading the Quality Assurance program to assure the use of the best method of measuring quality.

In review of the data, we note that there is one area in which a patient listed under sepsis was transferred from our hospital to another acute care facility and, therefore, should not be recorded in our data. This would change our mortality rate from 3 out of 6, (meaning 50%), to 2 out of 6, (being 33%). We do understand that this could be caused by late billing of the transferring hospital.

Thank you for providing us the opportunity to review this data and provide you with our input. As you are aware, it is very difficult to make judgements from data which does not include measures of severity as far as comparing hospitals. Also, the statistical validity of diagnostic categories with small numbers of patients is a concern. Again, the information provided will be used as a tool in our Quality Assurance program.

Sincerely,

Dennis L. Hamilton

Dennis L. Hamilton
President

DLH:ph

GALENA-STAUSS HOSPITAL
AND NURSING CARE FACILITY



October 14, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

RE: Comments on the HCFA Mortality Data
Galena-Stauss Hospital--Provider #14-0074

In one diagnostic category, ME, the indication is that our "Actual Mortality Rate" was 80% (4 out of 5 patients), which exceeds the "Range of Predicted Mortality Rates" for that category of 5 to 74%.

Our records indicate that all four of our ME patients had carcinoma as their primary underlying healthcare problem.

During the course of their medical treatment for their carcinoma, each did require admission at this hospital for dehydration, which was successfully treated in three of the four cases.

In other words, three of these patients who died were discharged alive from this hospital on the dates indicated:

[redacted] discharged 4/14/86; died 4/26/86 of cardiac arrest

[redacted] discharged 4/4/86; died 4/25/86 of carcinoma

[redacted] discharged 12/21/86; died 1/13/87 of carcinoma

As indicated, those patients did subsequently die within 30 days following discharge; their cause of death, however, was not dehydration.

We respectfully request that you recognize that difference between the hospital discharge diagnosis and the cause of death for those three patients. With that adjustment, all of our diagnostic categories would have actual mortality rates within the predicted ranges.

Sincerely,

Roger D. Hervey

Roger D. Hervey
Administrator

RDH/md

215 SUMMIT STREET / GALENA, ILLINOIS 61036 / (815)777-1340

GALESBURG
COTTAGE
HOSPITAL
695 NORTH KELLOGG
GALESBURG
ILLINOIS 61402-1600
AREA CODE 309
343-8131

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Galesburg Cottage Hospital appreciates the opportunity to comment on the hospital mortality information that is scheduled to be released to the general public in December, 1987. To that end, contained within this letter are our hospital's comments pertinent to the data and the methodology used to prepare it.



At the outset, it should be clearly understood that the quality of care delivered is of the utmost concern to the hospital's governing board, management and medical staff. Any quality problems or potential quality problems are dealt with through a comprehensive quality assurance program, whose purpose is to review the care delivered and investigate problems that develop. Through this process, if a problem is identified, action is taken in a prompt manner in order to correct the situation and is reported to key individuals and groups throughout the institution.

The hospital views the HCFA mortality data as part of a process of peer review. The mortality data, viewed in isolation, does not identify areas in which the Hospital provides "high quality" or "low quality" care or otherwise measure hospital performance. A mortality rate higher than predicted does not confirm the existence of quality problems, just as a mortality rate lower than predicted does not establish that the hospital provides "high quality care." Rather, the mortality data should be used to guide or focus peer review and to assist hospitals in identifying potential problem areas. The quality of care delivered at any institution can only be evaluated through the process of peer review. Statistical comparisons which, due to a number of intervening factors contributing to quality of care, can be very misleading.

In considering the methodology used to develop the mortality data, it should be noted that the data assumes each hospital's patients are average. The model does not include a measure of severity of illness or other indicators that may complicate an individual's illness. Without these types of measures, a pure statistical review or analysis of mortality data falls short of the goal of an indicator of quality.

The use of a 30-day post admission mortality rate also skews the data and would lead to some erroneous conclusions. In using a 30-day period, deaths that are unrelated to the condition of a patient that was under treatment at the time of discharge will be attributed to the hospital. These situations may not be within the control of the hospital and, therefore, serve to further mislead those who review the data at its face value.

The final flaw in the data from our perspective is the use of a patient's last admission. By using only the final hospital stay for patients, the sample of cases examined is skewed toward these resulting in death, which would result in both an overestimate of the probability of having a hospital stay result in death and a higher than expected death rate for hospitals that care for larger than average numbers of terminally ill patients. It would not be unreasonable to use all admissions as a basis for determining mortality rates since many patients (especially the elderly and those with severe illnesses) may be hospitalized many times during a given year. The use of all admissions would, therefore, be a somewhat more accurate reflection of an institution's mortality rate. Although as with the HCFA mortality rates, they cannot be viewed in isolation and should be a part of an overall peer review and quality review process.

In closing, we would like to commend HCFA for improving the process of releasing the mortality data to the public. Hopefully, the comments that many hospitals are submitting as a result of the current release of data will be seriously considered by the HCFA staff prior to any future such releases of data.

Sincerely,

Mark Hirshberg
Vice President, Operations

MH:pjl

Glendale
Heights
Community
Hospital

COMMENTS ON THE HCFA MORTALITY DATA
GLENDALE HEIGHTS COMMUNITY HOSPITAL

Medicare provider #140292

DATA VERIFICATION

The data used by HCFA indicates that of 422 Medicare patients, a total of 100 Medicare patients admitted to Glendale Heights Community Hospital died within 30 days of admission. Of these, 81 died while still a patient of the Hospital, while 19 died after discharge.

Our own records indicate that 496 individual Medicare patients were admitted in 1986. Presumably, the discrepancy between 496 and 422 reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the HCFA numbers of Medicare patients treated at Glendale Heights Community Hospital as their last hospitalization in 1986 is correct.

Our own records indicate that 83 Medicare patients died within 30 days of admission while still an inpatient, while 410 were still alive at the time of discharge. It is impossible to determine the percentage of the 17 patients dying after discharge who were in fact alive, as information concerning deaths after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in HCFA's analysis.

1505 Jill Court, Glendale Heights, Illinois 60139 (312) 858-9700

A Member Hospital of Adventist Health System North, Inc.

Glendale Heights Community Hospital, Inc.

Medicare provider #140292

INTERPRETIVE REMARKS

The actual mortality rate of Medicare patients who died within 30 days of admission falls into the range predicted by the HCFA in 14 of the 15 categories listed.

In one of the diagnostic categories, namely pulmonary disease, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate by 5%. This category also account for the overall rate computed by HCFA being 2 percentage points above the overall range of predicted mortality rates.

Several factors may account for this difference. They include the unique characteristics of the Medicare population that Glendale Heights Community Hospital serves, the accuracy of the HCFA data and statistical model and the small numbers of patients involved.

In re-reviewing the Medicare patients who died of pulmonary disease in 1986, it is obvious just how severely ill and debilitated the actual "typical" Medicare patient is who is serviced by Glendale Heights Community Hospital. In contrast to other neighboring hospitals who may service a "healthy" Medicare population, the average age of these patients at GHCH was 80 1/2 years, and a full 93% of them resided in surrounding area nursing homes. In 90% of the patients, the families or guardians had made a request to the physician and hospital that no heroic or extraordinary means be undertaken to keep their relatives alive.

The accuracy of the HCFA data is difficult to verify. Three dates of death were listed inaccurately by HCFA when we had indeed supplied them with the correct dates. More importantly, HCFA uses their bills when compiling their statistics and not the complete medical record. The bill only allows a maximum of five diagnosis to be listed and only has these five available to them when predicting the range of death expected at a hospital. The actual medical records of our patients dying of pulmonary diseases shows that most have more than five diagnoses. In fact, in 37% of the records, co-morbid conditions (additional diagnoses) used by HCFA to predict death, were not available to HCFA simply because their billing data could not hold them all.

As part of the ongoing process of providing quality care at GHCH physicians review every death that occurs in the hospital at their monthly department meetings.

A Quality Assurance Committee exists in the hospital to assure that this and other similar activities go on to continually monitor the quality of care so the hospital provides the best care to its patients. Patients have a right to this.

Glendale
Heights
Community
Hospital, Inc.

ERRORS TO BE REPORTED TO HCFA

Incorrect Dates:

1) [redacted] Date of death should be 11/18/86 not 11/19/86

2) [redacted] Date of discharge should be 3/27/86 not 3/28/86. Date of death should be 3/27/86 not 3/31/86.

3) [redacted] Date of death should be 9/30/86 not 10/1/86.

1505 Jill Court, Glendale Heights, Illinois 60139 (312) 858-9700

A Member Hospital of Adventist Health System North, Inc.

IL 80.3

Evangelical Health Systems

Good Samaritan Hospital
3815 Highland Ave., Downers Grove, IL 60515 (312) 963-5900

HCFA DATA ANALYSIS

GOOD SAMARITAN HOSPITAL welcomes the opportunity to respond to the recently published HCFA mortality data. Good Samaritan Hospital's actual mortality rates did not fall outside the predicted ranges for any of the diagnostic categories. However, because we feel that mortality data can be appropriately used to guide or focus medical peer review, Good Samaritan Hospital elected to analyze categories where it appeared that the actual rate ranked higher than average in the predicted ranges.

After medical peer review, it was confirmed that the HCFA methodology was not able to account for several characteristics which contributed to the actual cause of death.

For example, Good Samaritan Hospital is an open-heart surgery and diagnostic cardiovascular referral center affiliated with Loyola University. Consequently, patients are referred and admitted with a history of previous severe cardiac problems. In analyzing the deaths in the Severe Acute Heart Disease category, we determined that these patients were admitted to our telemetry unit with extensive myocardial infarctions or multiple system deterioration and therefore did not meet indications for surgical intervention. A substantial number of patients received temporary pacemakers in an effort to sustain life. In a majority of these cases, the severity of onset of the acute cardiac processes and significant end-stage conditions contributed to the cause of death.

In the cerebrovascular category, the majority of patients were unresponsive on admission, with an expected outcome of death as a result of the terminal stage of their condition.

Our review identified the following repeating factors throughout the various diagnostic categories:

- A significant number of patients were admitted from nursing homes with existing debilitating conditions.

- Death was the expected outcome as a result of the terminal stage of the patients' disease processes.

- These patients had more significant co-morbid conditions than the number included in HCFA's model.

Thus, the factors which caused the actual mortality rates to fall into the upper end of the predicted ranges were patient-specific characteristics which made Good Samaritan admissions differ significantly from the "average" patient reflected in the HCFA data.

It was also noted that within a particular category labeled "Low Risk," current government-mandated guidelines for coding of clinical data forced cases with acute conditions, which should have been included in the Severe Acute Heart Disease category, to be placed in a less severe grouping. For example, several patients with underlying severe acute heart disease were admitted and coded as having a principal diagnosis of the less severe manifestation of their illness (i.e., admitted with ischemic heart disease with known chronic severe coronary heart disease). This type of coding, which is mandated for payment mechanisms, is felt to bias mortality analysis.

Good Samaritan Hospital acknowledges the value of using mortality statistics as a mechanism with which to screen clinical data and identify areas which warrant a more in-depth focussed review. However, as stated by the JCAH and AHA, Good Samaritan Hospital is aware that statistical indicators are not direct measures of quality; and as demonstrated by the above analysis, any determination about actual quality of patient care can only be made as part of a case-oriented medical peer review process.

Evangelical Health Systems

Good Shepherd Hospital
450 West Highway 22, Barrington, Illinois 60010 (312) 381-9600

HCFA DATA ANALYSIS

All of GOOD SHEPHERD HOSPITAL's actual mortality rates by diagnostic category were within or well below the predicted mortality ranges. We are pleased to have the opportunity to review data generated by external review agencies. Although mortality data represents a rather limited indicator of clinical competence, we will continue to review this and other reports, as well as internally generated clinical profiles, to ensure ongoing high quality care at this hospital.

Good Shepherd Hospital acknowledges the value of using mortality statistics as a mechanism with which to screen clinical data and identify areas which warrant a more in-depth focussed review. However, as stated by the JCAH and AHA, Good Shepherd Hospital is aware that statistical indicators are not direct measures of quality; and any determination about actual quality of patient care can only be made as part of a case-oriented medical peer review process.

GOTTLIEB
MEMORIAL HOSPITAL

Medicare Provider No. 140008 October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

We have received the mortality statistics that your department has compiled and are taking advantage of this opportunity to comment on them.

Since mortality review has been a traditional quality assurance program at our hospital, we evaluated the data both as an index of quality care and as an opportunity to gain new insights into patient care issues. The statistics presented, however, failed to shed much light on the effectiveness of this activity. For example, it is not clear to us that there is a significant correlation between death within 30 days of admission and the quality of care during hospitalization.

Indeed, as you state, it is very difficult to draw any meaningful quality assurance conclusions from this data. Death, in itself, does not represent the failure of the health care delivery systems except in those areas where appropriate intervention can forestall the event in an effective manner. If the statistics could reflect the failure of that intervention, they might perhaps be more useful. We attempt to determine these facts within our internal quality assurance process.

We recognize that this is the first step in an evolving process and look forward to the development of more useful data collection techniques that will allow us to continue to improve our health care delivery system.

Sincerely,

Ira H. Goldberg

Ira H. Goldberg
President

gc

Harvard Community Memorial Hospital
Harvard, Illinois 60033 • Phone: 815 / 943-5431

October 19, 1987

RE: Hospital Mortality Data Released by HCFA December, 1987
Medicare provider number 14-0144 0196

To Whom It May Concern:

Whoever views the attached mortality data needs to be aware that this data, viewed in isolation, does not measure hospital performance. The data could be used to help direct certain quality assurance activities in a hospital, but the data certainly should not be used as the only basis for judging the quality of care rendered by a particular institution. I say this even though in our particular case, the data could be construed to demonstrate what a quality institution we are in all areas. Although we are a quality care giver, this data does not make the yardstick anyone should use to measure quality. It does not have sufficient parameters to make it useful for measuring quality without additional detailed study.

Sincerely,

John M. Seegers bem
John M. Seegers
Administrator

JMS:bem

cc: JMS file

herrin hospital

HERRIN, ILLINOIS 62948
618/942-2171

COMMENTS CONCERNING HCFA MORTALITY RATES

The Herrin Hospital Utilization Review Committee evaluated the HCFA mortality rates and makes the following comments:

1. THE DATA PRESENTED IS NOT ACCURATE

   Three categories were tested and the hospital's certified data were as follows:

	Total Cases	Deaths	Mortality Rate
Cancer	114	31	27%
Cerebrovascular Accidents	80	20	25%
Severe Acute Heart Disease	81	30	37%

   Since an identical patient population was studied it must be concluded that there is a serious flaw in the methodology used by HCFA to conduct this study.

2. THE PATIENT AGE DISTRIBUTION IS CRITICAL IN ANALYZING MORTALITY DATA

   It is important to know the age at which the patients died. Rural hospitals have a much higher average age than urban hospitals for the same patient populations. It is not sufficient to group all patients into an "over 65" category.

3. THE NATURE OF THE FACILITY'S THERAPY PROGRAMS MUST BE IDENTIFIED.

   The majority of the nation's rural hospitals do not provide aggressive cancer therapy. They do provide terminal care for cancer patients after the urban medical centers have finished.

4. SMALL HOSPITALS OFTEN HAVE TOO SMALL A PATIENT POPULATION TO PROVIDE A SIGNIFICANT SAMPLE SIZE IN EACH DIAGNOSTIC CATEGORY.

   Obviously 8 or 10 patients are not enough to base conclusions upon.

5. EXTENUATING CIRCUMSTANCES MUST BE CONSIDERED.

Herrin Hospital's Medicare patient population includes twice as many nursing home patients as the average hospital. This situation is created by the concentration of nursing homes in this community. These patients all suffer from chronic illnesses, and many are terminal at the time of admission.

HIGHLAND PARK HOSPITAL
718 Glenview Avenue
Highland Park, Illinois 60035
(312) 432-8000

October 26, 1987

William I. Roper, M.D.
Administrator
Health Care Financing Administration
Department Health and Human Services
Room 309-G, Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C.

Dear Dr. Roper:

Thank you for the opportunity to comment on mortality statistics developed by the Healthcare Financing Administration (HCFA) for Highland Park Hospital (Healthcare Provider #140108). We have reviewed the information and have the following comments of which the public should be made aware.

The reliability of a statistical model to predict hospital mortality rates is very limited. The model used by HCFA fails to consider several factors which have a significant impact on mortality. Examples are stage of illness, psychological condition and the patient's general health status. In this model, only Medicare patients are included. Most importantly, the predicted mortality rate cannot be used to indicate the quality of care in any hospital, because significant factors which influence the risk of death are excluded from the calculations. Therefore, the predicted mortality rates should not be a basis for comparing quality between institutions. The public should be cautioned against making these comparisons by HCFA because hospitals treat different levels of acutely ill patients. Our hospital mission should not be solely measured in terms of pure statistics, but also in terms of qualitative aspects of healthcare.

The data for Highland Park Hospital indicates that the actual mortality rates for the 16 diagnostic categories are in all instances within the predicted range of mortality.

Our review of all the data has provided supplemental information which the public should find useful in interpreting the HCFA data for Highland Park Hospital.

- One patient [redacted] is living and HCFA indicates him as deceased.

- One-third of all Medicare patients admitted to our hospital are not considered in the statistical base.

There are several significant services which Highland Park Hospital provides which affect statistical mortality rates. Highland Park Hospital provides acute patient care in such areas as trauma and emergency services, cardiac care, intensive care, oncology in addition to full medical/surgical specialty care.

- Highland Park Hospital operates a hospice program for the terminally ill. Approximately 15% of the deaths the HCFA statistics were in Highland Park Hospital's hospice program. Because HCFA includes these patients in the data, the mortality rates are severely overstated. For example, adjusting the cancer category for hospice patients results in Highland Park Hospital falling to the lowest possible rate of predicted mortality in treatment of cancer patients.

- Highland Park Hospital operates an oncology unit and program dedicated to the treatment of cancer. Of the 188 deceased patients in the HCFA statistics, 37% or 70 people had a primary or secondary diagnosis of cancer upon admission to the hospital. Highland Park Hospital's oncology service is so well known in our communities that we tend to serve more acutely ill patients.

- Sixty-six percent of those who passed away were so acutely ill upon admission that they were admitted to the hospital through the emergency room. This factor is not evident in the data prepared by HCFA. Further, over 42% of the patients were so ill upon admission that they were placed in intensive or cardiac care units. Finally, over 66% of the deceased patients had a "Do not Resuscitate" order or had prepared a living will in accordance with the wishes of the patient's family. This is another indication of the severity of illness Highland Park Hospital treats.

These are significant factors to consider when reviewing mortality rates. These factors have not been considered in the HCFA model. Highland Park Hospital and our medical staff have a well-established and ongoing quality assurance program which focuses on monitoring and improving care. Highland Park Hospital agrees with the goal of informing the public about quality of care, but would request that an accurate methodology be used so as not to confuse the public about this extremely important issue.

Highland Park Hospital appreciates the opportunity to provide these comments.

Sincerely,

Mark Newton

Mark Newton
Vice President
Planning and Marketing

MN:wnk

Hinsdale Hospital

120 North Oak Street
Hinsdale, Illinois 60521
312/887-2400

October 27, 1987

Department of Health and Human Services
Healthcare Financing Administration
The Administrator
Washington, D.C. 20201

SUBJECT: Mortality Statistics, Hospital #140122

Dear Mr. William Roper:

Attached is a copy of the selected mortality information effecting Medicare patients treated at Hinsdale Hospital in 1986. As you can see, our overall percentage is in the low end of the predicted mortality range and we are pleased to see that we do not exceed any categories listed in your predicted mortality rate column.

However, we would like to take this time to point out two areas of concern in regard to mortality data releases. In the future to check for accuracy and confirmation of your database, can you provide the medical record number as well as identification number of the patient? This would save a good deal of time as we review the information sent to us by you for accuracy and validity.

Secondly, as stated by you, the purpose of this type of data release is to allow hospitals to determine the actual death rate versus the expected in the Medicare population we service. One critical step missed in the sophisticated statistical techniques utilized by you is the area of severity of illness at the time of admission. How sick is the patient at the time of admission to the hospital?

We are a 465 bed hospital located in the western suburbs of Metropolitan Chicago and have chosen to utilize a severity of illness measurement into our database since 1984. We were an original beta test site for the MediQual Company which produced MEDISGRPS Plus, a severity of illness information management system.

Using the severity of illness tool and applying it to the two categories where we are at the accepted higher range of the predicted mortality rates we have found the following points of information. The two categories measured are pulmonary disease and sepsis.

PE PULMONARY DISEASE

Vol/Mort	Identified by us/Mort
47	44

17 = severity of 2 at time of admission
23 = severity of 3 at time of admission
1 = severity of 4 at time of admission
1 = severity of 1 at time of admission
2 = non applicable

The tool allows us to focus on the charts that fall in the area of severity 1 and 2 and determine the effectiveness of care given to these patients. We can pattern out the physician profile and determine efficiency as well as expected mortality.

SE SEPSIS

Vol/Mort	Identified by us/Mort
12	12

4 = severity of 4 at time of admission
8 = severity of 3 at time of admission

We would not focus on any of the above deaths due to the fact that they were admitted in a severity classification of 3 or 4 at the time of admission.

This above information will be followed by the Medical Services Evaluation Committee as well as the Surgical Services Evaluation Committee and if any areas of concern are noted, the information is forwarded on to the Department Chairman as well as the Department members.

I too believe that information on hospital mortality rates can be useful to our institution but only when used as I have just described with an additional statistical measurement of severity of illness.

We at Hinsdale Hospital are proud to be able to state that we have the ability to apply toward the predicted range of mortality rates you have provided to us the added measurement of severity. We are among a handful of about one hundred hospitals out of the three thousand hospitals in the country who are able to do this to our data base.

We strongly urge you as you move into the publication of the December 1987 mortality issuance that you preface the limitations of this type of release when it does not factor the critical point of severity of illness at the time of admission.

Thank you for allowing us the appropriateness of response and even though Hinsdale Hospital is well within the predicted range of mortality rates, we cannot overly stress the importance of severity of illness at the time of admission.

Sincerely,

Barbara J. Murphy

Barbara J. Murphy, RN, MBA
Director of Quality Assurance

BJM/lp

Holy Family Hospital

100 North River Road
Des Plaines, Illinois 60016
(312) 297-1800

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Enclosed you will find our response to Health Care Financing Administration (HCFA) selective mortality information for 1986.

Sincerely,

Sister Carol Anne

Sister Carol Anne
President and Chief Operating Officer

lm
enclosure

Holy Family Hospital

100 North River Road
Des Plaines, Illinois 60016
(312) 297-1800

October 26, 1987

Response to HCFA Mortality Data for 1986
Medicare Provider Number: 14-0105

Upon receipt of the released Health Care Financing Administration's (HCFA) data regarding mortality rates of Medicare patients, Holy Family Hospital showed an actual mortality rate of 13%. This percentage was compared to an expected range of 10% to 16%.

Through its Quality Assurance Program, patient deaths are examined by a committee of physicians who review pertinent information of hospitalized patients. This same process is utilized to review the quality of care provided to all patients.

In calculating mortality for Septicemia, Holy Family Hospital noted a small sample size of 26 patients, 16 of whom expired. In this instance, the predictability range was slightly exceeded. After a review of each case by a Physician Committee, it was declared that the management and treatment of these patients was consistent with the high quality of care rendered to all patients.

It is important to note that each of the deceased septic patients was admitted with overwhelming infections and the average patient age was 80.4 years. More than 60% (62.5%) of these patients were received from nursing homes. Fifteen of the sixteen patients or their families (94%) asked that extraordinary measures not be performed to extend their lives.

All other diagnostic categories fell within the expected mortality ranges. Viewed in isolation, statistics are not the true measurement of quality medical care, nor are they significant indicators of probable outcomes or hospital performance.

The mission of Holy Family Hospital is to provide a system of quality health and related services that allows individuals and families the choice of care appropriate to their needs. Through a multidisciplinary Quality Assurance Program, Holy Family Hospital consistently assesses the quality and appropriateness of care received by each patient.

Submitted by: Sister Carol Anne
Sister Carol Anne, President
and Chief Operating Officer

1555 N. Barrington Road
Hoffman Estates, Illinois
60194
Telephone 312 843-2000

Humana Hospital
Hoffman Estates

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Mr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Hoffman Estates supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of the hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally they may assist health care consumers in udnerstanding the extensive quality control systems in place in hospitals.

Our hospital's Medical Records and Quality Assurance Departments have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Robert G. Wolleben
Associate Executive Director

RGW/lg

Hyde Park
Hospital

October 20, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for sharing with us the mortality information about short term acute care hospitals which treated Medicare patients in 1986 that you plan to publish in December. The mortality information about Hyde Park Hospital for Medicare patients is accurate.

Our only comment is that fifteen out of the ninety-nine patients did not die in the hospital but rather did so after discharge. We understand that you are including these individuals in your information because they died within 30 days of their last admission in 1986. There is some concern about including this information in the hospital's Medicare mortality rate because there may have been other unknown factors which may have contributed to their deaths.

At any rate, we are grateful for the opportunity to review this information prior to its publication and await the results of your review in its totality.

Attentively,

A. A. Chacon

Armando A. Chacon
President

5800 S. STONY ISLAND AVENUE CHICAGO, ILLINOIS 60637-2099 (312) 643-9200
IL 104

ILLINI COMMUNITY HOSPITAL



October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

This letter is in response to your letter to me dated September 21, 1987.

We have verified the information which you furnished as an attachment to your letter.

Even though our actual mortality rate fell within the predicted range, I have concerns about the publishing of this information, as follows:

1. The mortality data includes deaths which occurred after a patient's discharge from the hospital, which deaths may have occurred from causes unrelated to the care received within our hospital.

2. Some of the deaths included in our data involved patients in the "swing bed" program, which we understand were not to be included in the hospital mortality data information. In other words, the discharge date from the hospital rather than the discharge date from the swing bed should have been used.

3. Illini Community Hospital has an exceptionally high percentage of Medicare patients, many of whom are in their late eighties or nineties. By using only the final hospital stay for patients, the sample of cases examined is skewed toward those resulting in death, which should result in both an over-estimate of the probability of having a hospital stay result in death and a higher than expected death rate for hospitals that care for larger than average numbers of terminally ill patients. (In other words, we feel that we do care for a larger than average number of terminally ill patients.)

640 W. Washington St. Pittsfield, Illinois 62363-1397

(217) 285-2113

4. Having field tested MediQual's severity of illness indexing system earlier in my career, I am fully convinced that ignoring the severity of illness or disease staging in a payment system or in the review of the quality of care provided is a serious mistake.

5. The HCFA model seems to circumvent the peer review process.

6. Reportedly, HCFA agrees that, "viewed in isolation, mortality rate information supports no conclusions relative to quality of care." Nevertheless, the public is likely to draw unfortunate conclusions from this data.

In summary, it seems unfortunate to me that the government is creating an adversarial climate with health care providers. Given the decreasing resources with which to provide health care, it becomes increasingly important that we all take a proactive role in enhancing the accessibility and quality of care, and work towards finding more cost effective ways of delivering that care without compromising quality.

Sincerely yours,

David L. Brown, FACHE, CPQA
Administrator

DLB/he

cc: Dawson Dean, President, Board of Directors
John Conroy, District V.P., HCA
Vicki Moore, QA Coordinator
Rod Clow, Marketing/PR

INGALLS

Ingalls Memorial Hospital
One Ingalls Drive, Harvey, Illinois 60426
312-333-2300

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

The following comments are in response to your communication dated September 21, 1987, regarding your plans to publish selected Mortality Data.

We recognize that consumers have a legitimate interest in obtaining useful, reliable information on the quality of care available to them. To this end, Ingalls applauds your attempt at consumer advocacy with the caveat that objective, fact-finding analysis and distribution of information are essential to accomplish this goal. Our reservations, therefore, are not on the release of this isolated mortality data, but instead on its potential for public misinterpretation leading to unnecessary confusion and apprehension, exactly the opposite of your laudable intentions.

In particular, the problem is that mortality data in and of itself, does not measure quality. It is indeed a valuable instrument in our pursuit of quality assurance, however, quality can only be effectively evaluated through a repertoire of well organized, all inclusive peer review. Simplistic statistical comparisons can lead to erroneous interpretations of data.

In fact, quality care is of utmost concern to us at Ingalls and is evaluated on a continuing basis. Our evaluation process includes a review of mortality as well as all other elements such as appropriateness of care, adherence to established care/practice criteria, patient care outcomes and care requirements for each patient, all of which are required to truly measure quality. This process is required by the Joint Commission on Accreditation of Hospitals. In its most recent survey of our hospital, JCAH found our quality review process met its requirements which includes the review of all mortalities for quality and appropriateness of care. If quality problems are identified, corrective action is swiftly taken. The hospital and its medical staff are prepared to take any and all steps necessary to insure quality and utilize mortality data in this task.

We must note a specific technical concern with the HCFA data. It has never been demonstrated that your model detects differences in quality patient care. There are too many variables such as severity of illness, transfers from other healthcare facilities, general state of health, etc., which are not accounted for. There is also no control for the type of patients treated by each hospital. For example, Ingalls operates Centers of Excellence in cardiology and oncology, treating a disproportionate share of critically ill, terminally ill and aging populations which may well have different mortality rates from the "average" hospital.

We are also concerned that your data applies to Medicare patients only (which represent only 38 % of the whole) and includes deaths within 30 days after admission. Our data includes deaths that occurred after discharge representing 20% of the total. Of that number, approximately 37% died from causes unrelated to the reason for admission. Also, there are three patients [redacted] included in our data who were never hospitalized here.

As a 700 bed not-for-profit institution whose sole mission is to provide quality medical care, we support and actively pursue all activities aimed at guaranteeing the public every opportunity to make an informed decision regarding their choices in seeking that care. While we recognize that mortality data is an internal instrument of value in measuring quality, we hasten to add that it is only one element in its evaluation. Therefore, in your media release of this information, we trust you are as committed to accurate public understanding as we are to delivering quality care. We petition you to emphasize its limitations in usage to the consumer and its potential for misuse in evaluating quality healthcare. Furthermore, we pledge our support in future endeavors to improve community awareness of quality healthcare.

Sincerely,

Thomas P. Herzog
Executive Vice President
and Chief Operating Officer

TPH:slr

JFK
John F. Kennedy Medical Center

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

To Whom It May Concern,

We are in receipt of the Health Care Financing Administration's (HCFA) selected mortality rate information and, we thank you for sharing that information with us prior to publication. It is our understanding that these statistics are exclusively Medicare cases for the year 1986 with expirations which occurred within 30 days of admission to our hospital, including cases where the death could have occurred after discharge from our facility, but still; within that 30 day time frame.

John F. Kennedy Medical Center's (JFK) Governing Body, Administration, and Medical Staff is committed to quality patient care. We have numerous methods in addition to mortality data to measure the quality of care provided at our facility. And because we have always measured the quality of patient care by physician review and not mortality statistics, the Administration and Medical Staff found your statistical information to be limited as it relates to quality measures, yet helpful in directing our peer review process. Certainly when any possible area of concern is identified, further investigation is warranted and, in this particular instance, peer review was performed.

We agree that consumers should have access to valid and useful information relative to the quality of patient care. However, the HCFA statistical model is misleading in some respects:

1) Your model has never been evaluated as a valid means for detecting deficiencies or differences in quality.

2) It does not measure severity of illness, therefore hospitals treating unusually large numbers of severely ill patients may have a higher than predicted mortality rate, and John F. Kennedy Medical Center falls into that category.

5645 West Addison Street Chicago, Illinois 60634 312/282-7000

None the less, we utilized it as a guide for directing our peer review process to gather more specific information on the area in question in order to be assured that quality care was given to each individual case in this category. In reviewing the statistics we focused primarily on those cases falling outside of the predicted mortality ranges. This prompted peer review in the category, "Severe Acute Heart Disease".

A group of speciality physicians reviewed each individual case, we immediately learned that eight (8) cases had not expired within our facility because they had been discharged prior to their death. By excluding these 8 cases our mortality rate dropped from 51% to 47% which falls within your "Predicted Mortality Rate Range" in that particular category.

Furthermore, the patients treated at John F. Kennedy are unusually complex, having characteristics not recognized by the HCFA statistical model, but certainly requiring note. Our patient types (Medicare) are more critically ill with 79% of our cases admitted through the Emergency Department. As I am sure you are aware, emergency admitted patients are critically ill upon admission, and in a state of illness more severe than elective admissions. This supports our indicating that JFK has an unusually high number of severely ill patients admitted to our hospital. Because your model does not take into account severity this was not recognized in your statistics. Additionally from your statistics we were able to derive that 34% of the cases in the category "Severe Acute Heart Disease" died within 48 hours of admission. Typically, cases where death occurs within the first 48 hours of admission are classified by the Joint Commission on Accreditation of Hospitals as non-institutional deaths, and not attributable to a hospital's net death rate. Therefore, a more accurate figure based on usual statistical calculations indicate a mortality rate for JFK of 14% in the category of "Severe Acute Heart Disease" when you deduct the cases where deaths occurred outside the facility and within 48 hours of admission.

Again, your mortality data was useful as a screening mechanism for directing our ongoing peer review process. We will continue to place the highest priority on quality patient care in support of John F. Kennedy Medical Center's Mission Statement. We are confident in the efforts of organizations such as the Joint Commission on Accreditation for Hospital's and the American Hospital Association in their ongoing investigation of methods for determining hospital quality that rely on measures other than mortality rates, and I assure you that John F. Kennedy Medical Center will support these efforts and communicate such to our community.

Sincerely,
JOHN F. KENNEDY MEDICAL CENTER

Peter Rusin
Executive Director

PR/nlj

La Harpe Hospital
La Harpe, Illinois

Provider Number: 14-0241

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

LAKE FOREST HOSPITAL
660 North Westmoreland Road • Lake Forest, Illinois 60045 • 312 234-5600

October 27, 1987

COMMENTS ON THE HCFA MORTALITY DATA

Data Verification

HCFA data indicates that of 1,036 Medicare admissions during 1986 a total of 126 Medicare patients admitted to Lake Forest Hospital died within 30 days of admission. Of these, 97 died while still a patient of the hospital, while 29 died after discharge. Our own records indicate that 1,707 Medicare admissions occurred in 1986. Presumably the discrepancy reflects the multiple admissions of individual beneficiaries, those patients who may have died within the hospital after a 30 day period, or those patients who were transferred from different hospitals to Lake Forest. Our own records also indicate that of the 126 Medicare patients who died within 30 days of admission while still an inpatient, 28 were still alive at the time of discharge. Two patients had the wrong dates of death listed, indicating death after discharge while they actually had died while in the hospital. One patient was discharged to an ECF, but died the same day therefore making death appear as an inpatient. It is impossible to determine the percentage of the 28 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record, so the information from sources that we are allowed to contact may be incorrect.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Unique Services Resulting in Higher than Average Mortality

- Lake Forest Hospital was the first Lake County hospital to have an oncology department, therefore patients from an extensive geographic area utilized these services, rather than where their attending physician practiced.

- Many of the cancer deaths occurring in 1986 are patients who have been treated for many years and have had multiple inpatient admissions as well as outpatient visits. Their deaths are not unexpected,nor do they reflect adversely on the care delivered.

- Lake Forest Hospital has a linear accelerator used by several area hospitals for continued radiation treatment of their patients.

- Lake Forest Hospital Has an active hospice program which includes outpatient and inpatient care.

- Lake Forest Hospital regularly receives transfers from several area nursing homes. These patients often require acute care despite poor prognosis or terminal conditions.

Results of Medicare Record Review

- All of the patients listed were Lake Forest Hospital patients.

- All patients who died while hospitalized at Lake Forest Hospital were reviewed. It was determined that if death was not imminent upon admission, acute changes occurred in the patient's condition during their stay that resulted in an expected death.

- All of the deaths of patients in the low risk category were due to complex high risk co-morbid and/or chronic disease conditions. The manner in which the primary diagnosis is selected causes many cases to fall into a low risk group when the actual cause of death would place them in a very high risk group. The primary or final diagnosis is selected by determining , after study, what the patient was primarily treated for during the hospital stay. If a complex or high risk condition arises toward the latter part of the stay, that often is not coded as the primary diagnosis.

- All patients discharged prior to death were reviewed. There were 29 patients listed in this category. There are three errors. 2 patients died in the hospital rather than after discharge, and 1 patient died after discharge. This 1 patient was in an extended care facility.

- Of the remaining 25, 4 patients were in extended care facilities as Medicare beneficiaries (1 was a hospice patient) receiving a high level of care.

- 11 patients were sent or returned to nursing homes.

- 7 patients were receiving home care through the hospital Home Care Agency. In addition, 1 of these patients was receiving Hospice care.

- Only 3 patients were discharged without further services. Contact with each patient's physician revealed that these patients were stable on discharge, however they all had severe chronic disabling conditions which resulted in their "not unexpected" deaths.

Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	25	8	24	9
CE -- Cerebrovascular Accidents	5	3	5	3
GC -- Gastrointestinal Catastrophes	3	0	3	0
GI -- Gastrointestinal Disease	5	0	5	0
GU -- Urologic Disease	0	0	0	0
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	3	1	3	1
HM -- Severe Chronic Heart Disease	7	2	7	2
HS -- Severe Acute Heart Disease	5	1	5	1
ME -- Metabolic/Electrolyte Disturbances	3	0	3	0
OP -- Orthopedic Disorders	0	0	0	0
PN -- Pulmonary Disease	12	5	12	5
RN -- Renal Disease	3	1	3	1
SE -- Sepsis	3	0	3	0
TR -- Severe Trauma	3	0	3	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	20	8	22	6
Total -- All Categories	97	29	98	28

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

LAKE FOREST HOSPITAL CORRECTIONS TO DEATH DATA

Patient ID Number	Surname First 6 Ltrs	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Prinicple Diagnosis	Prinicple Procedure
[redacted]		CA	67	M	03/17/86	04/15/86	04/15/86	1538	8703
Correction to above - Patient was not in hospital at time of discharge but in ECF - Dates are same.									
[redacted]		UN	85	M	11/22/86	12/04/86	12/05/86	4351	3323
Correction to above -							12/04/86		
[redacted]		UN	71	F	05/05/86	05/07/86	05/08/86	7991	3404
Correction to above -							05/07/86		

IL 121.3

LAKEVIEW MEDICAL CENTER

812 NORTH LOGAN AVENUE
OFFICE OF THE PRESIDENT DANVILLE, ILLINOIS 61832 (217) 443-5201

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Lakeview Medical Center appreciates the opportunity to comment on the data contained in the forthcoming December 1987 public release of hospital mortality information. The Health Care Financing Administration is to be commended for pursuing the objective of assisting the public to make more informed decisions related to the quality of hospital care.

Reviewing the pre-release data for Lakeview Medical Center confirms that it is substantially accurate. We are pleased to note, too, that Lakeview Medical Center falls well with the norm limits in each DRG category contained in the release.

However, there are several concerns regarding the public release of such data.

For instance, the Lakeview Medical Center data includes at least 15 patients for whom there is no explanation in the release that their deaths did not occur in our hospital, nor that they may not have died from the medical condition for which they had been hospitalized and that, therefore, their deaths may not be relevant to the hospital mortality data.

Not withstanding the HCFA disclaimers in the release, the data does not account for nor explain the variables that may exist within each diagnosis, nor does the data account for the individuality of each human condition. Variables are lost in averages and defy explanation when published in the form chosen by HCFA.

Specifially, the data reported for Lakeview Medical Center under CA (Cancer) does not reflect our extensive Hospice program for the terminally ill, predominately cancer patients. Nor does the data explain the significance of our geographic location in an area which

HSA statistics identify as having an extraordinarily high incidence of cancer. The data does not reflect the impact on cancer incidence resulting from our Cancer Center which attracts patients from a 60 mile radius area. Consideration is not given to the extended period over which a patient may have received treatment or that the patient may have chosen not to receive life-extended therapies. Nor is there explanation that patients reported under other admitting diagnoses resulting in death had been known patients under treatment for terminal cancer.

Not withstanding good intention, there appear to be fundamental weaknesses in the HCFA data release which have real probability of resulting in misinterpretation by the public and the sources the public turns to for information because they lack background knowledge and expertise to interpret the data. There is considerable danger that the data could encourgage inappropriate health care decisions based on misplaced fear about a condition, treatment or provider. Such fear would be encouraged by insufficient understanding of what the data means.

Even though HCFA states in the release that this information is not to be used as an isolated singular quality measure, such raw data may very well confuse rather than enlighten public decision making. It very likely will result in mistaken or erroneous health care evaluations. The data may not be intended to be the only measure of quality but it is our opinion that it will certainly be interpreted that way by the public.

To accomplish the commendable HCFA objective of providing the public with useful and reliable information, we believe there should be substantially more reinforcement of the fact that an individual's quality of life, age, sex, physical and medical history, hereditary factors, pre-existing conditions, accident outcomes, lifestyle abuse and neglect are all major variables and contributors to death from an illness or health condition. Without highlighting all of these variables, averages in reporting the outcome of human health experiences and conditions are most inadequate and unreliable as statistical verities.

It is also our recommendation that, in assessing hospital quality of care performance, there should be some methodology for incorporating meaningful data on physician patient management since the physician plays a primary role as director of patient care.

Considering the wide range of quality indicators and variables affecting hospital care, of which mortality data in only one, the following are suggestions for consideration in future data collection and release:

1.) The use of 30-day post admission mortality data should not credit a hospital for deaths that are unrelated to the condition for which the patient was under treatment at the time of discharge;

2.) There should be more emphasis in explaining that, by using the last admission, the sample of cases examined is biased toward those resulting in death and therefore overstates the probability of a hospital stay resulting in death. Also, using the final hospital stay reflects a higher than expected death rate for hospitals that care for a larger than average number of terminally ill patients, eg, Hospice program, Cancer Center, Trauma Center, etc., without identifying institutions with these kinds of speciality services differentiations;

3.) There should be additional emphasis pointing out that higher death rates are largely a function of the type of patient and the severity of their condition than a measure of quality care since a hospital that treats any diagnostic category with a higher than average likelihood of death will have a higher mortaility rate regardless of how high the quality of care. Consideration should be given to more defined severity indexes in the calculations and data;

4.) There should be a supplementary method in using 30-day post-admission mortality data to eliminate attributing to a hospital deaths unrelated to conditions for which patients may have been hospitalized and patients who die after discharge from a hospital in a setting over which the hospital has little or no control;

5.) Serious consideration should be given to coordinating and correlating with the existing peer review process to avoid competitive credibility pressures and confusion in the public eye, and more appropriate use of mortality data as a quality review screen within the hospital physician network that will focus efforts toward individual diagnoses and physicians within a given hospital.

Over the last several years Lakeview Medical Center has strengthened its emphasis on qualtiy assurance, peer review, medical staff utilization and patient care management. We have enjoyed a most successful cooperative input from our physicians. We rely greatly on periodic acreditation review, and state licensure and health department scrutiny. Official certifications and quality commendations are constant stimuli to an aggressive qualtiy commitment.

HCFA is to be commended for collecting and reporting data such as contained in the mortality release. It is most appropriate to direct use of this information toward the professional community for improvement of quality. However, we questions making such data available for indiscriminate public consumption as a judgment of quality.

We are grateful to HCFA for the opportunity to review the upcoming mortality data release and submit our comments. The recommendations

made herein are in the interest of assuring that the public is more adquately assisted to identify quality and that such information will be used to their best advantage in selecting and receiving quality hospital care.

Yours truly,

Richard V. Livengood, President

cc: Senator Paul Simon
Senator Alan Dixon
Representative Terry Bruce
IHA, Ken Robbins, President
AHA, Carol McCarthy, President

LITTLE COMPANY OF MARY HOSPITAL

2800 WEST NINETY-FIFTH STREET EVERGREEN PARK, ILLINOIS 60642 TELEPHONE GARDEN 2-6200

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Human Health Services
P. O. Box 26684
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity of commenting on the mortality rate information that you have provided us. A review committee composed of the Professional Staff, Administration and Quality Assurance staff of Little Company of Mary Hospital has reviewed the information provided.

While we have concluded that no major problem regarding mortality exists at our institution, please be assured that the information will be incorporated in the Hospital's Quality Assurance Program.

Little Company of Mary Hospital has been pleased to provide quality health care service to the community for fifty-nine years. Our physicians, staff and the area PRO work on a continuing basis to assure that our patients receive quality and compassionate health care services for which Little Company of Mary Hospital is noted.

Sincerely,

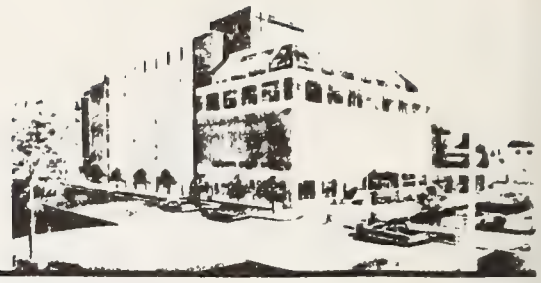
Sister Kathleen McIntyre, LCM.

Sister Kathleen McIntyre, LCM
President

Gerald M. Casey, M.D.
President, Professional Staff

SKMCI:an

Loretto Hospital



645 South Central Avenue · Chicago, Illinois 60644-9987 · Tel. 626-4300 848-3730

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Our hospital has had the opportunity to review the mortality data that was sent to us in September.

In regard to your specific concern, please be informed that we could not find any records that were inaccurate regarding patient admission to our facility.

In general, we find the data representing Loretto Hospital (Medicare Provider Number 140083) to be indicative of good overall performance for a relatively small inner city community hospital. Specifically though, the hospital has found that the actual mortality rate for severe acute heart disease was actually lower than that displayed in the HCFA Data Report due largely to sequencing errors. In fact upon analysis of the specific data, while acute cardiopulmonary arrest was found to be the terminal event, other clinical factors than heart disease were found to be the underlying cause.

We concur with the Illinois Hospital Association in their findings that the use of a 30 day post-admission mortality rate attributes to hospital deaths unrelated to the condition of the patient that was under treatment at the time of discharge. Secondly, using the last admission will overestimate the probability of having a hospital stay result in death since the sample of cases examined is biased toward those resulting in death.

Thank you very much for allowing us to screen this data and provide comment before public release. Reviews of this nature, along with additional developed analysis of practice patterns, should help continue to maximize the quality of care provided our patients.

Sincerely,

Sister Marion

Sister Marion
President and
Chief Executive Officer

Serving The Communities Since 1939

MB:pw

IL 127

Lutheran Hospital
501 Tenth Avenue
Moline, Illinois 61265
309/757-2611

Kenneth D. Moburg, President

October 20, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Washington, DC 20201

Dear Dr. Roper:

This is a response to your letter and information dated September 21, 1987. After review and analysis of the information, I would like to provide you with the following information. This information is being provided in the hope of providing clarity to the mortality rates in your document which you will be providing to the community.

From an overall perspective, we are satisfied with the results of the information you have submitted to us. The data itself seems to be reasonably accurate. To the extent the model has been presented to date, the analysis seems to be appropriate. Of course, any attempt to directly correlate this data to the ability of the hospital to provide quality health care to its patients would not appear to be appropriate. This is because the kinds of facts and information which will be contained herein were not available to you as the data was being gathered and analyzed.

The overall mortality rate for Lutheran Hospital of 18 percent is at the upper level of predicted mortality rate for at least two very obvious reasons. First, the deaths that fall into the diagnostic category of cancer; as well as a number of other deaths which fall into several other areas including urologic disease, pulmonary disease, renal disease, and sepsis, to name a few; also include patients who were long-term cancer patients although their final cause of death may have been due to the shutdown or collapse of some other bodily function which was aggravated by their cancer. Another significant factor which caused the mortality rates at Lutheran Hospital to be high in a number of areas is that a larger-than-average number of patients who come to Lutheran for care are coming from nursing homes. This is because a number of the physicians who practice at Lutheran Hospital have involvement with nursing homes and choose to utilize the services of Lutheran Hospital. Since these patients are already debilitated in certain ways, causing them to reside in nursing homes, it is obvious that their conditions put them at greater risk for increased illness, increased morbidity and mortality than would the general population at their particular ages.

In addition to this information regarding the overall mortality rate, I believe it is appropriate to share further information about some of the specific diagnostic categories and related mortality rates, as well as comments about the predicted mortality rates.

Regarding cancer, as stated earlier, the hospice program at Lutheran Hospital significantly affects the relationship between the actual mortality rate as compared to the predicted mortality rate. As a matter of fact, 79 percent of all cancer deaths in 1986 were deaths of individuals within the hospice program. Simply stated, participants in the hospice program are there by virtue of the understanding that death is imminent, and they have chosen to participate in that program as a way for them and their loved ones to gain additional support during the dying process with its difficulties.

In review of those individuals who died due to cerebrovascular accidents, it was noted that many of these individuals had been either nursing home patients or individuals who had had previous medical incidents. In addition to that, it was noted most of these patients had multiple diagnoses indicating the severity of their illnesses.

Another diagnostic category which deserves additional comment is that of urologic disease. As noted earlier, many of these patients died of a urologic disease that had complicating conditions such as cancer.

The next category of note is that of severe chronic heart disease. Although within predicted mortality rates, in review of these patients, it was noted that many of them were of a very advanced age with multiple medical conditions and many previous hospitalizations.

Another type of note is that of severe acute heart disease. It is noted that the actual mortality rate fell just below the range of predicted mortality rates. It is felt that in this particular situation, the quality of care provided at Lutheran Hospital is the reason for this particular situation. Lutheran Hospital has a separately identified cardiovascular unit with excellent trained staff and a very agressive approach to sustaining life.

The next area of note is that of pulmonary disease. Although again within predicted mortality rates, the actual mortality rate was toward the high end of that group. This is readily explained by Lutheran Hospital's specialty unit in pulmonary disease where many patients are referred initially and have, unfortunately, a number of subsequent admissions to deal with their pulmonary problems. Due to the referral nature of the respiratory program, more severely ill patients come to Lutheran Hospital.

Again as noted earlier, in areas such as renal disease and sepsis, although the rates fall well within the predicted rates, it was noted in review of these areas that many of the patients who die in these areas actually have cancer or other debilitating diseases which put the patient in a more compromised position.

Although all of the patients in these diagnostic categories had their charts reviewed following their deaths, as well as all patients who die at Lutheran Hospital, the information provided by you will be reviewed through the quality assurance program within the medical staff. In addition, this activity will be further reviewed by the board of directors of Lutheran Hospital. This is the ongoing procedure, which is carried out both through the hospital departments, the medical staff, and the board of directors, when any concern for quality is raised.

Thank you for the opportunity to respond to your information. I hope that in providing this information you are doing a service for the community. I also thank you for the opportunity to help communicate with our community about the kind of care that is given at Lutheran Hospital.

Very truly yours,

Kenneth D. Moburg
President

RLG:klp

Lutheran General Hospital

1775 Dempster Street
Park Ridge, Illinois 60068

Telephone 312/696-2210

October 27, 1987

The Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

RE: HCFA Medicare 1986 Mortality Data
Lutheran General Hospital - Park Ridge
Medicare Provider #140223

Dear Sir:

In response to HCFA's mortality data about Medicare patients treated at Lutheran General Hospital in 1986, we have serious concerns about the methodology. This is especially true because the data appears to be an indication of the quality of an institution when, in fact, it presents a skewed picture and therefore may mislead consumers.

We investigated the reliability of both the reported data and predicted mortality range. We also performed a thorough review of the records of individual patients who died to determine the cause of any deviations of our rates compared to the predicted ranges.

While the 13 percent overall mortality rate quoted by HCFA for Lutheran General appears to be accurate according to the method used, when all Medicare admissions and discharges for 1986 are taken into account, the overall mortality rate is actually 8 percent. Counting only the last admission in the year 1986 for patients who may have had multiple admissions during the year clearly produces a bias toward over-reporting of mortality, rather than an indicator of overall quality.

Quality care is essential for each admission of a patient to the hospital, including those admissions in which the patient has been discharged in an improved condition, possibly to return at a later date. Futhermore, the in-depth internal review of the individual records of the patients who died revealed considerably more about the healthcare status of these patients than is reflected by the mortality rate alone. This analysis indicates the effect of our being a tertiary referral hospital which by its nature admits patients who are more severely ill, rather than the existence of a concern about quality of care.

The Administrator
Health Care Financing Administration
Department of Health and Human Services
October 27, 1987

The difficulty in using HCFA's data to assess quality of care can best be illustrated by a description of some of the characteristics of patients in the pulmonary diseases category. Although age, as well as sex and some other associated conditions, is said by HCFA to be taken into account in determining the predicted range, severity of the patients' illnesses is clearly not considered.

Of those patients with pulmonary disease who died, the average age was 82, and 75 percent of the patients were more than 75 years old. Sixty of the 106 patients were transferred to Lutheran General Hospital from nursing homes, and almost 95 percent had significant other chronic illness documented on their record. As an indication of the severity of the chronic illness, 30 percent of the total group of patients with pulmonary disease who died also had advanced stages of cancer and 72 percent of those patients who died were in a "Do Not Resuscitate" category, requested by either the patient or the patient's family.

Similarly, in three other categories, that is, gastrointestinal catastrophies, sepsis and stroke, careful analysis of the records of patients who died also revealed a high incidence of chronic illness and an average age of 79 to 80. In patients who suffered from stroke, 39 percent had massive bleeding into the brain, Again, the patients in these categories include a high degree of chronic debilitating illness as evidenced by a 67 to 78 percent of "Do Not Resuscitate" status requested by either the patient or the family.

While we support HCFA's goal to provide reliable data to assist consumers in their decision about health care, Lutheran General Hospital is concerned that the data provided accurately reflect the quality of care rendered. The Quality Assurance program at Lutheran General Hospital provides surveillance of the care of all patients for possible adverse or unexpected outcomes. If such an adverse situation or outcome is identified, we take action immediately. Improvements instituted because of these peer review activities are the cornerstone of a quality health care institution.

Sincerely,

Harold A. Shafter

Harold A. Shafter, M.D.
Executive Vice-President and
Chief Medical Officer,
LUTHERAN GENERAL HOSPITAL

kd/0751

MACNEAL
Hospital

3249 South Oak Park Ave.
Berwyn, Illinois 60402
(312) 795-9100

VIA FEDERAL EXPRESS COURIER

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Enclosed you will find the response by MacNeal Hospital in Berwyn, Illinois, to the recent mortality information sent to us about Medicare patients treated here in 1986. Our Medicare provider number is 14-0054.

MacNeal also is interested in seeing continued refinement of the methodologies and data validation techniques HCFA is using in developing and measuring this information.

We appreciate the opportunity to respond in this fashion to this information prior to publication and look forward to seeing the published results this December.

Sincerely,

G T Hodges

Gilbert T. Hodges
Director
Public Relations

GTH:ms
Enclosure

HCFA RESPONSE

It has been estimated that the community served by MacNeal Hospital has twice the aged population of an average community, making it one of the oldest in the nation. In the greater Chicago area, MacNeal is a major provider of hospital care to patients over the age of 65 years. This 427-bed community teaching hospital's formal program of medical quality assurance has a 13-year history, and is under constant internal review and refinement. Hospitals traditionally review mortalities for patients who die in the hospital. The HCFA report supplements this information, reporting both deaths in the hospital and also deaths within 30 days of discharge.

For MacNeal Hospital there are no surprises in the HCFA data release showing all MacNeal mortality rates within the predicted ranges, despite our aged population. MacNeal reviews mortality and other outcome measures on a severity-adjusted basis in order to more accurately interpret it. MacNeal's quality assurance program reviews not only care provided by physicians, but also services provided by ancillary staff, in a careful, systematic and formal way.

MacNeal Hospital maintains a continuous exchange of information with its physicians in a mutual effort to continually monitor and improve the quality of care. MacNeal Hospital's physicians and staff have continually evidenced their commitment to quality care throughout the history of the hospital, and regularly contribute their time to quality assurance review activities. In addition to mortality, other outcomes such as morbidity, severity and re-admission are reviewed.

MacNeal Hospital agrees with HCFA in their statement that the 1986 mortality rates, though they are useful, do not necessarily indicate quality of care for any individual hospital. Our concerns parallel those expressed by the American Hospital Association (AHA), including the methodology utilized to develop the data. For example, as AHA indicates, the HCFA data assumes that each hospital's patients are "average," except with respect to the characteristics included in the statistical model. In addition, the model does not consider how ill patients were at admission (measures of severity), whether they were transferred from a nursing home or another hospital, were treated at home prior to admission, or if a variety of other important variables affecting patient condition were considered.

MacNeal concurs with the AHA in its caution regarding appropriate use of HCFA data. While we understand the government's continuing attempts to provide information as an aid to hospital quality assurance programs, we submit that mortality rates do not alone measure quality. We urge responsible management of this data, placing it in meaningful context should it be made public.

9724A

MARION MEMORIAL HOSPITAL

917 West Main Street • Marion, IL 62959 • 618-997-5341

MEDICARE I.D. #14-0184

October 26, 1987

ADMINISTRATOR
MERLE L. AUKAMP

BOARD OF DIRECTORS

L. C. CAVANESS
President

GLENN CLARIDA
Vice President

EDWIN SOLDNER
Secretary

DR. EVERETT E. JETER
NITA JOYNER
MICHAEL MALONE
R. D. MORGAN, M.D.
F. V. PUGEDA, M.D.
HERBERT D. REYNOLDS

Emeritus Members
CLARA BOATRIGHT
KENNETH POWLESS

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
Washington D.C. 20201

Dear Dr. Roper:

We appreciate the opportunity to comment on the public release of hospital mortality information by the Health Care Financing Administration (HCFA). Some errors have been found in the data that was submitted to us. In order to maintain the information in a confidential manner, the corrections are attached on a separate page. There are also some concerns regarding the HCFA model that need to be addressed.

The methodology used presents several reasons for concern. First of all, the statistical data may be misleading if there are only a small number of cases in a particular diagnostic category. In a small hospital, such as Marion Memorial Hospital, this is certainly the case in several categories. Secondly, the cause of death is not necessarily related to the principal diagnosis. A patient admitted for an orthopedic procedure could have died from a pulmonary embolus totally unrelated to the reason for admission. Therefore, classification by the principal diagnosis does not necessarily produce accurate mortality rates. Furthermore, it is inaccurate to include patients who expire after discharge from the hospital when it is unknown whether or not the cause of death is related to the admission. Thirdly, the data does not show the admission source of the patient. Patients admitted from the emergency room presumably would be in a more serious condition than other patients. Similarly, a patient transferred from a nursing home or other health care facility would already be in a compromised state of health. Fourthly, the mortality rates are skewed toward a higher mortality rate due to the fact that only the final hospital stay for each Medicare patient is counted. This practice discounts any previous admission when the patient was discharged alive. Lastly, this model makes no allowance for severity of illness or patient mix. HCFA's failure to consider secondary diagnostic codes ignores pre-existing chronic conditions and acute comorbidities. Obviously, a patient with multiple diseases or injuries and thus in a more severely ill condition would be more likely to die than a patient without these complications.

The HCFA data viewed on its own merit does not measure the quality of care provided by a hospital. Rather than public release, a more appropriate use of the data would be as a screening tool for guidance of further study by PROs and each hospital. I agree with the Illinois

A Municipally-Owned Hospital
Established in 1953

Hospital Association's letter of September 11, 1987 to Mr. Thomas G. Morford of HCFA that "it is important to provide the public with accurate, reliable methods of measuring quality of care, but only after an adequate model has been developed." HCFA has not adequately developed its model.

Thank you once again for the opportunity to comment on your release of mortality rates. I hope that HCFA will seriously consider these suggestions as well as the suggestions of other hospitals in future planning.

Sincerely,

Merle L. Aukamp

Merle L. Aukamp
Administrator

MLA:cdg

Enclosure

MARION MEMORIAL HOSPITAL
MARION, ILLINOIS

CORRECTIONS TO HCFA MORTALITY DATA

HIC#	LAST NAME	FIRST NAME	INFORMATION TO BE CORRECTED
[redacted]			AGE SHOULD BE 85
[redacted]			AGE SHOULD BE 83
[redacted]			AGE SHOULD BE 61
[redacted]			NAME SHOULD BE [redacted]
[redacted]			AGE SHOULD BE 85
[redacted]			EXP. DATE SHOULD BE 9-23-86
[redacted]			AGE SHOULD BE 80
[redacted]			AGE SHOULD BE 76
[redacted]			AGE SHOULD BE 75
[redacted]			AGE SHOULD BE 83
[redacted]			AGE SHOULD BE 89
[redacted]			AGE SHOULD BE 77
[redacted]			AGE SHOULD BE 76
[redacted]			NAME SHOULD BE [redacted]

Martha Washington Hospital

4055 North Western Avenue
Chicago, Illinois 60618
312/583-9000

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom it May Concern:

We have received and reviewed the hospital mortality information intended for publication in December. A simple check of names and dates revealed the following errors:

One patient (HIC # [redacted]) expired on 6/15/86, not 6/17 as stated in your report.

Another patient [redacted] is listed twice; HIC #, dates, and all information except names are the same.

The patient [redacted] who is listed as having expired on 11/24/86 actually died in this hospital on 6/9/87.

One patient [redacted] is female, not male.

Given the above errors we must wonder how reliable the rest of this information is, particularly for patients deceased after discharge.

For calendar year 1986, this facility had at least 1762 in-patient stays by Medicare benificiaries. Your report states that it was calculated on 957 cases. To calculate a death rate based on last admission only is misrepresentational. The use of a 30 day post admission mortality rate is also misleading. This figure may include deaths not related to diagnostic category (as may the other deaths reported) or to treatment received by the patient in this hospital.

We also feel that the use of the data item titled "Diagnostic Category" is deceptive, as it appears to be based on the Diagnosis Related Group (DRG) calculated for the patient based on principal diagnosis. The principal diagnosis may bear no relation to the cause of death; but the press and the general public do not have a technical understanding of the DRG assignment process.

In short, we feel that this report is statistically a faulty measurement of hosptial activity and prompts for erroneous conclusions. To publish such information is a disservice to both providers and users of health care services.

Sincerely,

Joseph T. Prekup
Administrator/Chief Executive Officer

JTP/pr
1277R

McDonough District Hospital

525 East Grant Street – Macomb, Illinois 61455 – 309/833-4101

COMMENTS OF THE HCFA MORTALITY DATA

McDONOUGH DISTRICT HOSPITAL

MACOMB, ILLINOIS

Medicare Provider No. 140089

Data Verification

The records of McDonough District Hospital indicate that the data used by HCFA for Medicare patients that died within 30 days of admission and were still patients of the Hospital at the time of their death are accurate. HCFA data for Medicare patients who died within 30 days of admission but had been discharged from McDonough District Hospital prior to their death are not verifiable from the patient's hospital medical records. The date of death is not a part of their hospital medical record since they were discharged prior to their death.

Remarks

McDonough District Hospital, a 155-bed non-profit facility located in Macomb, Illinois, serves the residents of the West-Central region of the State as a Regional Medical Center, Trauma Center, and Poison Control Center. The mission statement of McDonough District Hospital states that ". . .the primary purpose of its Board of Directors, management, medical, nursing, professional and support staffs and volunteers is to provide professionally organized comprehensive healthcare for the residents in this service region. In so doing, the Hospital strives to provide . . .high quality services and products. . .". McDonough District Hospital's responsibility to these communities, also documented in its mission statement, is "to provide a broad spectrum of health services, embracing patients' physical, spiritual, emotional and social needs, as well as the needs of patients' families and loved ones". Through the use of a Trust Fund, left to the Hospital in a private bequest, the Hospital is also committed to providing medical and extended care to elderly persons in these communities that lack the financial means to obtain that care. These documented mission statements demonstrate that quality of care is of the utmost concern to McDonough District Hospital's Board, management, medical, nursing and other support staffs.

The perspective of McDonough District Hospital as a medical facility is that an appropriate assessment of a hospital's performance is dependent upon a number of variables. Therefore, such an

evaluation requires a look at many quality indicators of which mortality is only one. McDonough District Hospital's current Quality Assessment Plan was implemented in March 1986 to enhance the provision of high quality care. Quality Assessment monitoring is performed by all hospital departments, and not just those required by the Joint Commission on Accreditation of Hospitals. A review of the quality of services provided by each department is performed monthly with concentrated efforts made to prevent problems from arising. Indications of potential quality problems leads to prompt investigation to determine if a problem, in fact, exists. Corrective action is initiated for verified problems. This method has proved effective without involving mortality rates. However, as a part of the Hospital's existing comprehensive Quality Assessment program, a monthly review of mortality and significant complications is conducted in each department of the Medical Staff. The HCFA mortality data serve to provide additional input into this process. The purpose of this monthly review is to monitor and evaluate all deaths that occur in the Hospital, and also to identify areas for review to determine if a quality problem exists or if other factors were involved, such as severity of illness, which is not reflected in the HCFA mortality rates.

Other organizations, including the Joint Commission on Accreditation of Hospitals, are investigating methods of evaluating hospital quality that rely on measures other than mortality rates. Indicators of quality are difficult to measure by an institution, however, McDonough District Hospital looks forward to the development of better measures of quality in their own Quality Assessment program.

Stephen R. Hopper
President/CEO

MEMORIAL
HOSPITAL

STEVEN T. MOBURG, Administrator

SOUTH ADAMS STREET / CARTHAGE, ILLINOIS 62321

(217) 357-3131

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Gentlemen:

Attached is our verification of data used by HCFA. We find that a total of 50 Medicare patients admitted to Memorial Hospital died within 30 days of admission. Of these, 42 died while still a patient in the hospital, while 8 died after discharge. Our own records indicate that 536 Medicare admissions occurred in 1986.

Please note the attached corrected copy of the patient listing. It is impossible to determine the percentage in each category of the 8 patients dying after discharge, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

We noted that none of the diagnostic categories revealed the hospital's actual mortality rate to fall outside the range of the predicted mortality rate.

We are concerned that the mortality rate released by HCFA will lead to misinterpretation by the public and other health care providers as there has been no allowance made for severity of illness within diagnosis, number of patients, nor the quality of care given those patients. Also, the report presently circumvents the peer review process.

An undue concern over the quality of care provided by the hospital is created by releasing the mortality rates. This could lead to unwarranted litigation and the misleading data that could be misconstrued to measure a hospital's overall quality of care.

We feel that the peer review process should be utilized in determining where a real problem exists. By providing data to the PRO's and hospitals, improvement in methods to measure quality of care for these selected diagnoses could be made, thus making the data more valuable.

During the past year it has been noticed by many hospitals that wasted dollars have been spent in duplicating functions of the peer review organizations and HCFA. A coordinated effort by HCFA and the PRO's should be made to release such data in the future.

Sincerely,

Steven T. Moburg
Administrator

jcb
Enclosures - 2

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors ID Number - 140081

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	3	1	4	0
CE -- Cerebrovascular Accidents	2	1	2	1
GC -- Gastrointestinal Catastrophes	1	0	1	0
GI -- Gastrointestinal Disease	2	1	2	1
GU -- Urologic Disease	0	1	0	1
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	2	0	2	0
HM -- Severe Chronic Heart Disease	4	2	4	2
HS -- Severe Acute Heart Disease	9	0	9	0
ME -- Metabolic/Electrolyte Disturbances	0	0	0	0
OP -- Orthopedic Disorders	2	0	2	0
PN -- Pulmonary Disease	10	1	10	1
RN -- Renal Disease	0	0	0	0
SE -- Sepsis	1	0	1	0
TR -- Severe Trauma	0	0	0	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	5	2	5	2
Total -- All Categories	41	9	42	8

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

GEORGE MARONEY
Administrator

Memorial Hospital of Carbondale

404 WEST MAIN STREET
CARBONDALE, ILLINOIS 62901
(618) 549-0721

October 15, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for the opportunity to provide an accompanying statement to the mortality data which you will be releasing to the news media. An auditing of the data, that you have provided us, has revealed no discrepancies.

I still find it perplexing that HCFA in all its publications, in one form or another, makes a statement to the effect that they believe information on hospital mortality rates are useful. However, they continue until additional statistical measures have been developed to deal with complex issues, such as severity of illness, HCFA cannot and does not recommend the use of the information by itself to make judgements about the quality of care in individual hospitals or to make comparisons amongst hospitals. I wholeheartedly agree with that statement and I respect the noble aim of anyone who seeks to quantify quality. However, I am perplexed when an organization such as HCFA publicizes information that they admit is tainted at its very best.

Despite what we have all heard about changes in where older and terminal people die, that being they die at home or in nursing homes not in hospitals which only care for acute patients, a great many very sick people come to the hospital in their final days of life and die. It is a very natural series of events. It might also be worth noting the average age of the patients. The average age of Medicare recipients, dying at Memorial Hospital, as defined by the diagnosis of cancer was 75, cerebrovascular accidents the average age was 87, and gastrointestinal catastrophes the average age was 80.

All too often those of us who deal with the media are concerned by the restraints the media have to operate under. There are just so many seconds of news time for a reporter on camera. They are often forced to over condense a subject down to a couple of phrases. The danger of producing flawed, grossly imperfect information and presenting that to the public as a way of evaluating health care leaves a lot to be desired.

Quality measures must be developed. Once those measures are developed they must be used to promote changes in the practice of medicine to improve the quality of care provided in this country. The approach as is presently being set forth, I feel,. has the potential for doing far more harm than good. Memorial Hospital, for instance, is one of a handful of hospitals in the State of Illinois that has been classified by the Federal Government as a rural referral hospital. That means that we treat, according to the Federal guidelines, far more critically ill patients than other rural hospitals. Our medical staff is far more specialized than others. By the very nature of Memorial's medical staff Memorial will draw to its facility more critically ill, complicated patients than other hospitals. A number of these are either in a terminal stage or will be determined to be incurable and over the course of various hospitalizations most likely will have a final hospitalization, at this hospital, which will result in their death. The level of severity of illness of your patients, the level of specialization of your medical staff, referral patterns, the age of your patients, all of these are factors which really are never brought to bear on the report being presented to the media.

An advisory was put forth on how Administrators were to compose their responses to accompany the HCFA report on Mortality. We were cautioned not to criticize the report because HCFA had made up its mind. This was the direction they were going to go and once HCFA's mind was set there was no changing or going back. I would hope Dr. Roper and his staff are not that intransigent and can evaluate the efficacy of their report and come up with a method that will assist hospitals and physicians in evaluating the quality of care and not allow the rules of bureaucracy to so limit their ability to regroup, to change, to modify.

One might think, from some of my comments, that Memorial had horrific mortality rates. Far be it, the rates Memorial experienced are well within the ranges of predictable mortality as set forth by HCFA. What concerns me is the process. What concerns me is stretching this to what some futurist would prophesy as a way of gauging the quality of a hospital's care. Hospitals and physicians would stop accepting certain types of patients, the hard patient, the patient that is too risky and send them someplace else so their figures would look good. It should not be a situation of hospitals taking only winners verses losers. It should be a situation of hospitals taking patients that are within their capabilities to treat, cure if possible, and if it is deemed appropriate be measured for quality, but be measured for quality in a different way than this present approach of the Federal Government.

Sincerely,

George Maroney
Administrator

jm

Memorial Hospital

4501 North Park Drive
Belleville, Illinois 62223
(618)233-7750

Harry R. Maier
President

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

This letter is in response to your letter of September 21, 1987 in which you transmitted selected mortality information developed by the Health Care Financing Administration for Medicare patients treated at Memorial Hospital during 1986. Memorial Hospital has expended a great deal of time and effort in reviewing this data.

By way of general comments, Memorial Hospital has found errors in HCFA's data regarding the total number of patients who expired, the number of patients who expired while hospitalized, and the total number of patients who expired following discharge. Memorial Hospital will be happy to provide you with a detailed breakdown of these errors. However, given the inherent weaknesses of HCFA's methodology in preparing this data, Memorial Hospital is not sure that any meaningful conclusions can be drawn from this data, even when corrected.

Memorial Hospital is a member of the Illinois Hospital Association whose staff has prepared an extensive analysis of the deficiencies in HCFA's methodology for collecting and reporting data regarding mortality information about Medicare patients treated in hospitals during 1986. Therefore, rather than to replicate their analysis, I am attaching copies of relevant correspondence from the Illinois Hospital Association regarding the inadequacies of the HCFA data. Memorial Hospital fully supports the conclusions drawn by the Illinois Hospital Association staff. In addition, Memorial Hospital supports the analysis by the American Hospital Association regarding deficiencies in the Medicare mortality data which make drawing any meaningful conclusions from such data impossible.

I trust that Memorial Hospital's position regarding the inadequacy of the HCFA methodology and the accuracy of the HCFA's Medicare mortality data is evident. If you have any questions concerning this matter, please do not hesitate to contact me.

Sincerely,

Harry R. Maier
President

HRM:dm
Enclosure

ILLINOIS
HOSPITAL
ASSOCIATION

September 11, 1987

Thomas G. Morford
Health Care Financing Administration
Department of Health and Human Services
HSQ-148-GNC
P.O. Box 26676
Baltimore, MD 21201

Dear Mr. Morford:

The Illinois Hospital Association (IHA) on behalf of its 226 member hospitals appreciates the opportunity to comment on the notice in the August 17 Federal Register describing the proposal of the Health Care Financing Administration for the public release of hospital mortality information.

Because the mortality rate data previously released was terribly inaccurate, by HCFA's own admission, what is to lead the health care community to believe that this data is any less flawed?

IHA has several concerns that should be addressed, including:

- o No allowance has been made for severity of illness within diagnosis or number of patients;
- o Qualifiers concerning the data should be more prominent;
- o Consideration has not been given to the consumer ramifications of releasing misleading data to the general public; and
- o The report circumvents the peer review process.

There are two primary problems with the methodology HCFA has chosen for determining whether hospitals' actual mortality rates are within their "expected" ranges. First, and most important, the expected values are not based on a model that accounts for variations in severity of illness within diagnoses and/or patient mix. As a result it is likely that the model is statistically biased. If the model is biased as a result of the exclusion of important causal variables, then the predicted mortality rates based on the model are biased as well. Therefore, these rates should not be used to establish "normal" ranges. Hospitals should not be compared against an objective standard unless that standard is accurate. HCFA's standard is not.

Secondly, even assuming the expected values to be accurate, where there are not a large number of cases to compute actual mortality rates,

The Center For Health Affairs
1151 East Warrenville Road
Naperville, IL 60566
312-357-9370

Statistics alone cannot be utilized in a review of a given institution's quality of care. Statistical indicators serve only as a screening tool to identify areas in which to focus peer review in determining where a real problem exists. Therefore, the most productive use of mortality data is not public release, but rather in providing data to PROs and hospitals to assist them in focusing their medical review activities and improving the method for selecting diagnostic areas for further study. Following these activities, the PRO would then be able to release to the public information that is a more accurate measure of an institution's quality of care.

IHA feels it is important to provide the public with accurate, reliable methods of measuring quality of care, but only after an adequate model has been developed. Even then, sharing this data with the public should be the charge of the peer review organization to assure the most accurate information finds its way to the health care consumer. The HCFA data releases show a lack of confidence in the peer review process and wastes millions of dollars by duplicating the function of the peer review organization. If only for economic reasons, data release should be issued either by HCFA or the PRO and certainly not both.

IHA is concerned that rather than informing and educating the health care consumer, mortality data releases serve only to confuse the public by giving the impression that mortality statistics can be used to measure quality. This provides a disservice not only to hospitals, but the very public HCFA intends to benefit from this information.

IHA appreciates the opportunity to comment on this proposed HCFA data release and hope the suggestions of the health care community will no longer be ignored by HCFA when planning future data releases.

Sincerely,

Kenneth C. Robbins
President

ILLINOIS
HOSPITAL
ASSOCIATION

OFFICERS
Chairman
Richard V. Livengood
Danville
Chairman-Elect
Sister Sheila Lyne, RSM
Chicago
mmediate Past Chairman
Michael M. Mitchel
Chicago
Treasurer
Ted L. Eilerman
Granite City
Secretary
Charles B. Van Vorst
Urbana
President
Kenneth C. Robbins
TRUSTEES
James M. Brophy
Elk Grove Village
William Casey
Urbana
John G. Eresian
Chicago
Gerald M. Harman
Belleville
Robert A. Henry, MD
Rockford
Roger D. Hervey
Galena
Jerry A. Hickam
Carbondale
David R. Hosler
Du Quoin
Richard S. Kowalski
Galesburg
Robert J. Krug
Chicago
Robert M. Magnuson
Elmhurst
Sister Mary Anthony
Menting, SCSC
Breese
Harlan H. Newkirk
Chicago
Keyton H. Nixon
Joliet
Roland D. Olen
Quincy
Patrick L. O'Malley
Chicago
D. David Sniff
Lincoln
Ronald G. Spaeth
Highland Park
W. Garland Strohl
Shelbyville
Robert Vanecko, MD
Chicago
Joyce Washington
Forest Park
Norman F. Webb, II
Pekin
The Rev. Carl A.
Zimmerman
Oak Brook

October 5, 1987

MEMORANDUM

TO: Chief Executive Officers, Member Institutions

FROM: Mark Brooks, Manager, Finance
Joel Cohen, Director, Data and Policy Analysis

SUBJECT: HCFA MORTALITY DATA RELEASE

As you are aware, the Health Care Financing Administration (HCFA) is planning to release hospital mortality information to the general public in December 1987. Last year HCFA released a similar set of data to the public. This year's release, however, is very different. First, HCFA is providing an opportunity for you to review and comment on the data prior to the December publication. You should have received your mortality data from HCFA by this time. In addition, your comments on your mortality data, which are due at HCFA by October 28, 1987, will be included when the data is released to the public in December. IHA is preparing a data report which may be helpful to you in qualifying your comments. This report, described in more detail on pages four and five of this memo, is based on comparative data for the fourth calendar quarter of 1985 and the first quarter of 1986. Our efforts to secure more timely data from the Illinois Health Care Cost Containment Council were resisted by Council staff. When more complete data for 1986 are released to IHA by the Council, we will share them with you.

In our opinion, HCFA has made some fundamental methodological errors in the model used for their data release. First, the use of a 30 day post-admission mortality rate will attribute to the hospital deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge. Second, by using the last admission, the sample of cases examined is biased toward those resulting in death which will overestimate the probability of having a hospital stay result in death.

The purpose of this memorandum is to provide information that will describe the data that will be forthcoming from the IHA. The intent of the IHA data package is to provide you with additional

The Center For Health Affairs
1151 East Warrenville Road
Naperville, IL 60566

information that will help you understand your HCFA data, as well as assist in responding to inquiries from the public and the media.

As described in an IHA August 21, 1987 memo, the HCFA data release will contain the following information.

1. An alphabetical listing arranged by State, of hospitals with city and state location. Included in this listing will be a page location, if appropriate, where comments provided by the hospital can be found.

2. For each hospital, the number of Medicare beneficiaries treated in 1986. (Special attention should be given to the fact that the HCFA data release pertains to Medicare beneficiaries versus total discharges.)

3. For each hospital, the actual proportion of Medicare beneficiaries treated who dies within 30 days of admission. In all instances, the admission used will be the last in 1986 for any given patient.

4. Each hospital's expected mortality rate based on a nationally representative statistical model. The expected mortality rate will be presented as a range which will include 95 percent of its probable values.

5. Hospital specific information for the following medical conditions:

   . HIGH RISK

   - severe acute heart disease
   - severe chronic heart disease
   - pulmonary disease
   - renal
   - severe trauma
   - sepsis
   - metabolic and electrolyte disorders
   - stroke
   - cancer
   - gastrointestinal catastrophes

   . LOW RISK

   - gynecologic disease
   - urologic disease
   - orthopedic disease
   - low risk heart disease
   - gastrointestinal disease
   - ophthalmologic disease

It is the last admission for patients that is used in HCFA's mortality rate computations. By using only the final hospital stay for patients, the sample of cases examined is skewed toward those resulting in death, which should result in both an overestimate of the probability of having a hospital stay result in death and a higher than expected death rate for hospitals that care for larger than average numbers of terminally ill patients.

The overestimate of death rates will occur simply because the elimination of prior hospital stays for patients who died will reduce the death rate denominator (i.e. the total number of cases) without changing the numerator (i.e. the number of cases with death as the outcome). Although the sample is selected with a bias toward the severely ill -- that is, cases which ended in death -- the predictive model does not adequately account for that bias. Thus, hospitals that care for large numbers of patients who a priori would be considered likely to die are also likely to look like they have a higher than expected death rate. Their higher death rate, however, is going to be largely a function of the types of patients they attract and how those patients are dealt with in the HCFA methodology rather than their quality of care. For example, a hospital that attracts patients in any diagnostic category who are more likely than average to die will have a high mortality rate for that category regardless of how good their treatment is because those patients will be oversampled in proportion to all cases treated in the hospital. Furthermore, even if high quality care were to keep those patients alive longer than would have been the case otherwise, it would not be accounted for in HCFA's methodology because the life sustaining pre-death admissions would not be included in the computations.

HCFA has chosen a 30 day post admission mortality rate instead of an inpatient mortality rate. The 30 days was selected to reduce the variations in inpatient mortality rates that result from differences in the availability and use of post-hospital extended care services. Although the 30 day post admission mortality rate will reduce apparent variations in mortality due to differences in length of stay, it will also result in attributing to the hospital deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge or that resulted from the management of the patient at home or in a post-acute care facility. Other concerns regarding the HCFA model and the data release that have been expressed by the IHA include.

no allowance has been made for severity of illness within diagnoses or number of patients;

the report circumvents the peer review process;

> statistical analysis of mortality rates do not measure quality of care. They can, however, serve as a screen for further review.

HCFA itself asserts that viewed in isolation, mortality rate information supports no conclusions relative to quality of care. This, however, may not prevent unfortunate conclusions from being drawn.

Memorial Medical Center

VHA
Member of the Voluntary Hospitals of America System

PROVIDER NUMBER - 140148

COMMENTS ON HCFA MORTALITY RATES

HCFA is to be applauded for recognizing the importance of educating the public about quality health care.

While we agree with HCFA that the model which has been developed to predict mortality is not perfect and may offer limited usefulness as an indicator of quality, we also agree that this is a step in the right direction.

As stated in the HCFA notice: "We have started what will be an ongoing effort involving all interested parties in improving the accuracy of mortality predictions by refining the model and the methodology.

As a model for predicting mortality rates, the effort by HCFA is one of the best currently available and much improved over the 1986 publication. We believe it is not possible, however, to interpret the data as the sole measure of quality. **The public must understand this!**

217·788·3000 800 North Rutledge Street Springfield, Illinois 62781-0001

For Memorial Medical Center, all actual mortality rates fall within predicted ranges. This does not, however, necessarily reflect the result of the quality of care provided, and in fact, may be due to the severity of illness of the patient's treated or a result of random variations of analyzing small numbers in a particular sample.

There is risk that the public will draw erroneous conclusions about quality of care based on this data. It is possible that actual mortality in any category may be more indicative of severity of illness, random variation or other factors not accounted for in the model.

The more relevant question which should be asked is: Does the actual experience mean high-quality care was provided to severely ill patients or was routine care provided to patients who were not as ill? Either question is appropriate but cannot be answered by data in the HCFA study.

The range of predicted mortality, while very large in certain categories, does not represent a range of higher to lower quality. It does represent a range which attempts to account for variations within the population analyzed. Factors such as age, sex, complications and prior hospitalization vary tremendously among our patients and have significant effects on predicted mortality ranges.

Similarly, although actual experience falls within a predicted range, it is not possible to say whether quality, severity of illness or other factors determined final placement in the range.

Memorial Medical Center is a 600-bed hospital serving a broad geographic region in central and southern Illinois. As a teaching institution involved in research and education, Memorial Medical Center provides a full range of health care services to a broad spectrum of patients. Many of our patients are acutely ill. While we would like to represent the HCFA study as proof of the high quality of care we provide to our patients, we do not believe we can do so based on this data.

Memorial Medical Center, like most hospitals, is working to develop aggressive quality control and peer review programs. To monitor and evaluate quality of care issues across a broad range of factors has been, and will remain, top priority of our hospital.

HCFA is to be applauded for it's efforts, but additional indicators must accompany mortality rates to assure a complete and effective measure of quality. Efforts are underway by the JCAH and others to measure quality more comprehensively. These efforts should be supported and encouraged.

For Memorial Medical Center, all actual mortality rates fall within predicted ranges. This does not, however, necessarily reflect the result of the quality of care provided, and in fact, may be due to the severity of illness of the patient's treated or a result of random variations of analyzing small numbers in a particular sample.

There is risk that the public will draw erroneous conclusions about quality of care based on this data. It is possible that actual mortality in any category may be more indicative of severity of illness, random variation or other factors not accounted for in the model.

The more relevant question which should be asked is: Does the actual experience mean high-quality care was provided to severely ill patients or was routine care provided to patients who were not as ill? Either question is appropriate but cannot be answered by data in the HCFA study.

The range of predicted mortality, while very large in certain categories, does not represent a range of higher to lower quality. It does represent a range which attempts to account for variations within the population analyzed. Factors such as age, sex, complications and prior hospitalization vary tremendously among our patients and have significant effects on predicted mortality ranges.

Similarly, although actual experience falls within a predicted range, it is not possible to say whether quality, severity of illness or other factors determined final placement in the range.

Memorial Medical Center is a 600-bed hospital serving a broad geographic region in central and southern Illinois. As a teaching institution involved in research and education, Memorial Medical Center provides a full range of health care services to a broad spectrum of patients. Many of our patients are acutely ill. While we would like to represent the HCFA study as proof of the high quality of care we provide to our patients, we do not believe we can do so based on this data.

Memorial Medical Center, like most hospitals, is working to develop aggressive quality control and peer review programs. To monitor and evaluate quality of care issues across a broad range of factors has been, and will remain, top priority of our hospital.

HCFA is to be applauded for it's efforts, but additional indicators must accompany mortality rates to assure a complete and effective measure of quality. Efforts are underway by the JCAH and others to measure quality more comprehensively. These efforts should be supported and encouraged.

Mercy Hospital and Medical Center
Stevenson Expressway at King Drive
Chicago, Illinois 60616-2477

312.567.2000

MERCY

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Corporation
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Mortality Information

Dear Dr. Roper:

Representation of a mortality figure without representing the variables surrounding that figure is misleading. Unfortunately, this information determines the reader's perception of the quality of care delivered in the institution. We will now provide more information relating to the cases represented in four of the categories listed.

In the low risk heart disease category, four cases or 15% of the total were actually in the high risk heart disease category. However, when the physician made the correction, the correction was not submitted to Medicare.

It is rare to find a death caused by an exclusive disease. Factors which contribute to mortality include patients' poor nutritional status, the presence or absence of chronic debilitating diseases, age, and delays in seeking medical intervention. Sometimes patients and families along with their physician determine that the patient cannot benefit from extraordinary care; and, consequently, the treatment of the individual, is to provide ordinary means of comfort.

These statistics presented by HCFA include patients having one or more of these factors. Finally, HCFA data includes patients who expired within thirty days of discharge. In these situations, the cause of death may or may not be related to the mortality category addressed (e.g., accidental death).

After thorough medical record review, and realizing that the public has a right to this information as well, we now share our analysis.

Sincerely,

MERCY HOSPITAL AND MEDICAL CENTER

Sister Sheila Lyne, R.S.M.
President

SSL:b
Attachment

MERCY HOSPITAL AND MEDICAL CENTER
Chicago, Illinois

Category:	Factor:				
	Debilitating Chronic Disease (e.g., Cancer, COPD, Diabetes, End Stage Renal Disease, Poor Nutritional Status, etc.)	Age (90 or over)	Patient/Family Decision Regarding Extraordinary Means	Patients Expiring After Discharge Cause ?	Patients Expired Within 24 Hours of Admission
Urologic	54%	14%	43%	14%	7%
G.I. Catastrophies	43%	14%	36%	21%	-
Sepsis	50%	44%	-	-	7%
Low Risk Heart	58%	-	12%	15%	26%

HOSPITAL ID# 140113

Mercy Hospital

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Please see the attached comments by Mercy Hospital to be included as part of the December, 1987 publication of HCFA Mortality Data.

Upon review of the HCFA data, five (5) separate discrepancies were identified, including:

Patient ID Number (HIC)	Date of Discharge	Date of Death
	09/18/86	09/18/86
	06/03/86	06/03/86
	01/06/86	01/06/86
	03/19/86	Patient Alive
	10/24/86	10/24/86

These data errors are highlighted on the attached case lists.

If I may provide you with additional information, please contact me at (217) 337-2442.

Sincerely,

Bryon D. Pickard

Bryon D. Pickard, RRA
Administrative Director
Data Base Management

BP/rks

1400 West Park Street/Urbana, Illinois 61801/(217) 337-2000
A Member of the **ServantCor** Human Services Family

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

HOSPITAL ID# 140113

HCFA MORTALITY DATA RELEASE

After an extensive review and evaluation of the information contained in this HCFA Mortality Data Release, Mercy Hospital is submitting the following comments in an attempt to: (1) provide verification of the HCFA data; (2) explain the meaning of the HCFA data; and, (3) offer a response.

I. VERIFICATION OF DATA

HCFA Data		Actual Data	
Inpatient Deaths	- 101	Inpatient Deaths	- 104
Post-Hospital Deaths	- 57	Post-Hospital Deaths	- 53
	158	Patient Still Alive	- 1
			158

Of 158 identified Medicare beneficiary deaths, HCFA reports 101 deaths occurring during an inpatient admission, with an additional 57 deaths attributed to a 30-day post-hospitalization period. In fact, upon revew of this data, 104 of the reported deaths occurred during hospitalization, with 53 deaths attributed to the post-hospitalization period. The one additional HCFA reported death is a live patient who has had two subsequent admissions to Mercy Hospital during 1986 and 1987.

Although the accuracy of the HCFA data would be difficult to verify for all 53 out-of-hospital deaths, these figures are quite possible given the fact that almost 2/3 (62%) of the post-hospital deaths were patients considered terminal during their hospitalization. 41 of the 53 post-hospital deaths (77%) were patients who were transferred to another hospital, home health care, or extended care facility for continued care upon discharge.

II. MEANING OF DATA

HCFA Reported Data	
Mortality Rate	11%
Predicted Range	8 - 15%
Reported Cases	1,450

	Cases	Deaths
High Risk Conditions	456	121
Low Risk Conditions	483	14
All Other Conditions	510*	22*
	1,449	157

*Adjusted for Live Patient

II. MEANING OF DATA (continued)

The published HCFA mortality data indicate an 11% mortality rate for the reported 1,450 (1,499*) Medicare beneficiaries receiving treatment at Mercy Hospital during 1986. The causes for each mortality are further defined into 16 separate diagnostic categories, designated as being either a high or low risk condition. All other conditions, or diagnostic categories are designated as a separate group. Although Mercy Hospital is positioned within or below the range of predicted HCFA mortality rates in each of the 16 diagnostic categories, the Hospital feels it is necessary to reiterate the Illinois Hospital Association's position regarding the use and meaning of this data in measuring hospital performance. IHA emphasizes that:

> "It is the last admission for patients that is used in HCFA's mortality rate computations. By using only the final hospital stay for patients, the sample of cases examined is skewed toward those resulting in deaths, which should result in both an over-estimate of the probability of having a hospital stay result in death and a higher than expected death rate for hospitals that care for larger than average numbers of terminally ill patients.
>
> The overestimate of death rates will occur simply because the elimination of prior hosptial stays for patients who died will reduce the death rate denominator (i.e., the total number of cases) without changing the numerator (i.e., the number of cases with death as the outcome). Although the sample is selected with a bias toward the severely ill --that is, cases which ended in death-- the predictive model does not adequately account for that bias. Thus, hospitals that care for large numbers of patients who a priori would be considered likely to die are also likely to look like they have a higher than expected death rate. Their higher death rate, however, is going to be largely a function of the types of patients they attract and how those patients are dealt with in the HCFA methodology rather than their quality of care."

As an example, Mercy Hospital shows a 38% mortality rate for Medicare patients falling into the diagnostic category "Gastrointestinal Catastrophies." Eight of the 9 mortalities in this diagnostic category were admitted to Mercy for terminal care. In addition to their high risk gastrointestinal disease, all 9 death cases had additional HCFA-defined high risk co-morbid conditions during their hospitalization. The HCFA model only considers principle diagnosis.

This critical variable was found to be true of all but one of the 36 deaths designated as being due to a "Low Risk" or "Other" condition. The remaining one mortality was a patient who was admitted for terminal care in a semi-comatose condition, and later expired. These patterns parallel findings in each of the other diagnostic categories.

II. MEANING OF DATA (continued)

Even if the HCFA model was a true measure of quality of care, it does not account for the numerous life sustaining pre-death admissions to Mercy Hospital and other health care providers for many of these patients.

III. RESPONSE TO DATA

Mercy Hospital supports the belief that the public is entitled to meaningful data concerning hospital quality. However, it is also realized that there are limitations to this mortality data in its present form.

The Board of Directors of Mercy Hospital is committed to high quality patient care services. Through a cooperative effort with the Federal government peer review system, hospital and physician performance is monitored to assure that all Medicare patients receive safe treatment and quality health care. Mercy Hospital establishes, maintains, and supports, through the Chief Executive Officer and the President of the Medical Staff, an ongoing Quality Assurance Program. One component of the Quality Assurance process is an ongoing medical staff peer review assessment of each patient mortality. This quality of care review includes the entire patient population and is not limited to Medicare beneficiaries only. The information in turn is monitored and evaluated by the Quality Assurance Committee of the Board of Directors.

5025 North Paulina, Chicago, Illinois 60640
312/271-9040

Methodist Hospital
of Chicago



Bethany Methodist

Bethany Methodist Home
Methodist Hospital of Chicago
Bethany Methodist Terrace
Bethany Methodist Foundation
Diversified Management Resources
Diversified Residential Communities

October 27, 1987

Medicare Provider #140197

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for for the opportunity to respond to H.C.F.A.'s mortality data before its publication in the Federal Register.

Methodist Hospital of Chicago is the acute medical/surgical division of Bethany Methodist, a health care system chartered almost a century ago to provide geriatric care. As such, we treat the old and the very old.

In addition to the Mortality Data as it is reported on this print-out, I would like to add additional statistics for this facility in 1986.

Average age of expirations in this report: 81 years.

Total Medicare population: 2,331 out of 4,426.
(More than half were on Medicare)

Total cases in which nursing homes were the admission source: 1,366. (Over half of our Medicare population comes from nursing homes.)

In short, Methodist Hospital of Chicago's patient mix was primarily Medicare, or 2,331 of 4,426 discharges, in 1986. Of this number, more than half were admitted from skilled nursing facilities, or 1,366 our of 2,331.

Thank you again for this opportunity to clarify the data as it stands.

Sincerely,

Stephen A. Dahl, M. Div., D. Min.
President and Chief Executive Officer

Michael Reese Hospital and Medical Center
Office of the President
Lake Shore Drive at 31st Street
Chicago, Illinois 60616
(312) 791-3545

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Efforts to measure the quality of care that hospitals and medical institutions provide their patients should be commended. We dispute, however, the use of mortality rates as as accurate index of performance. We believe that other indices, in place at most major medical centers, should be perfected and utilized.

Michael Reese, located near the heart of Chicago, is one of the largest private medical centers in the United States. It is a general acute-care hospital as well as a center of teaching and research. Its patient population is widely varied by socioeconomic group. Mortality rates, which have been carefully monitored for decades at Michael Reese by individual physicians, department heads, and the institution itself, serve better as a warning flag than a measure of care. Traditionally, an unusually high or low mortality rate targets an area to be closely scrutinized by our staff. As with any question of propriety of care, unusual rates are addressed promptly by Michael Reese's extensive quality assurance program, formally in place since 1973 informally here since the hospital's beginning.

As to the data to be released in December by the Health Care Finance Administration, we feel it necessary to raise some important questions concerning the model itself.

First, although the model appears sound in theory, it has not been scientifically tested and proven. Its practical validity remains doubtful. If the model is inaccurate, public confusion, such as that experienced last year, will undoubtedly ensure.

Second, HCFA's model does not account for actual cause of death. For example, in the case of a cardiac arrest patient whose actual cause of death may be pneumonia, HCFA's figures are misleading and inappropriate.

Third, the severity of illness suffered by a patient is not adequately accounted for by HCFA's model. Although an attempt has been made to correct this flaw, exposed in last year's data, underlying complications are not readily identified and subsequent adjustments are not accurately made.

Despite these caveats, we welcome HCFA's data for two reasons: Hospitals will now easily be able to trace a patient who has left the institution and dies (currently this is too costly a process for most institutions); and smaller hospitals who have no quality assurance programs in place will be forced to implement one.

Sincerely,

Marvin B. Klein
President

MBK/wmh

MORRIS HOSPITAL

150 West High Street/Morris, IL 60450/(815) 942-2932

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

In reviewing the data presented by the Health Care Financing Administration, it is noted that Morris Hospital falls within the predicted mortality rate for the given diagnoses. Although we are pleased with this information, we agree that a single review of data cannot be used to make a judgement regarding the quality of care a hospital provides. Other factors must be taken into consideration, such as the type of patients reviewed, the focus of care that a facility provides, etc. Some hospitals may, by their nature, attract the more terminal patient. At present, mortality rates do not reflect a severity of illness adjustment nor is there an accepted norm for quality surveillance. Mortality studies, with refinement, may become useful as one indicator of quality.

In specific regard to Morris Hospital, it is important to note that 37% of the patients that Morris Hospital services are Medicare patients. This older patient population characteristically has a higher severity of illness, i.e. patients who are sicker. These patients typically have chronic conditions such as heart and respiratory diseases, or terminal illnesses. In this patient population, many suffer from co-morbid conditions (previously existing conditions, such as diabetes) which increase the likelihood of mortality. These patients comprise 85% of Morris Hospital's total mortality rate. Fifty-four percent (54%) of the patient mortality study were age 80 and over, forty-five percent (45%) were between 65 and 80. Additionally, 28% (22) of the patients listed did not die in the hospital itself, 54% (12) of these were in nursing homes. There were five names of Medicare age deaths that appeared in our internal records that did not appear in the study.

Primarily, statistics are used to identify areas for review. These statistics come from many sources, such as the mortality studies presented here by the Health Care Financing Administration or the Joint Commission on Accreditation of Hospitals or other agencies. Any indication of a problem through review of statistics is brought to the attention of the Quality

Assurance Committee and further investigation takes place. In regard to mortality review, departments of the medical staff at Morris Hospital review all patient deaths on a monthly basis. Physicians on staff review each death to confirm that the care that the patient received meets prevailing standards of care. The review process may yield insights on ways to reduce death. If corrective actions are warranted, such steps are taken.

Mortality data is only one aspect of Morris Hospital's ongoing quality assurance program. The quality assurance program is set forth by its Board of Trustees and carried out through a Hospital-wide Quality Assurance Committee. As part of the quality assurance program, patient care is routinely reviewed by the Medical Staff through a process called "peer review" to confirm that care is delivered to patients appropriately and efficiently.

In conclusion, although we statistically fall in the predicted rates, we do not consider mortality data meaningful in isolation. At present, our peer review systems and overall quality assurance program focus on our goal... to provide optimum health care within the framework of Federal and State legislation and the standards issued by the Joint Commission on Accreditation of Hospitals.

Morris Hospital's Quality Assurance Program is dedicated to inspiring confidence in the services the hospital provides, and is an ongoing program.

Sincerely,

Clifford L. Corbett

Clifford L. Corbett
Vice President

CLC/cj

MORRISON COMMUNITY HOSPITAL
303 North Jackson Street
Morrison, Illinois 61270

Phone:
815/ 772-4003

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Re: Letter of 9-21-87 from Wm L. Roper, M.D., Administrator

Morrison Community Hospital (MCH) has several comments concerning the Health Care Financing Administration (HCFA) plan to publish selected mortality information about all short term acute care hospitals which treated Medicare patients in 1986.

It is important to emphasize that MCH does not believe that the HCFA data, in and of itself, is a measure of hospital performance and/or quality of care even though the MCH actual mortality rate for all causes as published by HCFA falls within the HCFA range of predicted mortality rates.

HCFA has made some fundamental methodological errors in the model used for data release. First, the use of a 30 day post-admission mortality rate will attribute to hospital deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge. Second, by using the last admission, the sample of cases examined is biased toward those resulting in death which will overestimate the probability of having a hospital stay result in death.

In addition, the reliability of the HCFA model is unknown. It may accurately and reliably reflect the relationship between a small number of patient characteristics and the risk of death, but it does not reliably predict hospital mortality rates. Further, the relationship of this risk of death to quality of hospital care is unknown.

Of the 15 diagnostic categories, Morrison Community Hospital lies outside of the range of predicted mortality rates in 6 categories. There are 3 categories below the expected range and 3 categories above the expected range. Of the 3 categories above the expected range, 2 of the categories contain only one patient each. This does not represent a statistically significant sample. These 2 categories will have actual mortality

rates of either 0% or 100% making the comparison to a range useless and of no value to anyone. This exemplifies that sample size for small hospitals is inappropriate for drawing any conclusions concerning the data.

In closing, Morrison Community Hospital does not accept the HCFA data as a reliable indicator of hospital performance and/or quality of care even though MCH falls within the range of predicted mortality rates. The model used contains some fundamental methodological errors and the reliability of the results is unknown. Additionally, even if the model were appropriate and reliable, the sample size used in small hospitals, such as MCH, make the use of a predicted range useless.

Sincerely,

Kent L. Brown

Kent L. Brown, Administrator
Morrison Community Hospital

Medicare Provider Number 14-0173

KLB:mb

An Affiliate of
The Jewish Federation of Metropolitan Chicago
A Permanent Affiliate of
Schwab Rehabilitation Center
A Teaching Associate of
Rush-Presbyterian-St. Luke's Medical Center

MEDICARE PROVIDER # 14-00-18

Mount Sinai Hospital Medical Center
Administration
California Avenue at 15th Street
Chicago, Illinois 60608

650-6435

October 29, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: HFCA Mortality Data - 1986

Gentlemen:

We have received the HCFA Mortality Data for the calendar year 1986.

Our records indicate that there were 2294 Medicare discharges in calendar year 1986. This reflects multiple admissions of individual patients during the year. However, HCFA only counts the last admission of the patient to a hospital, and those patients who died within 30 days of the admission date.

HCFA data indicates a total of 185 Medicare patients expired within 30 days of admission, with 167 expired while still inpatients, and 18 expired post-discharge (non hospitalized). Our own records indicate that 171 of the patients listed by HCFA expired while inpatients; with 13 expired post-discharge (unverified). The remaining patient death is listed with an expiration date prior to the discharge date, but according to our records, the patient was discharged alive from our hospital.

Due to the short time frame, our institution has not been able to review each record to determine the cause of death. Therefore, we wish to stress that the data from HCFA is based on the principle diagnosis code which may not necessarily be, or have any relationship to, the cause of death.

It is our hope that when HCFA releases this information to the public in December, that they make note of this potential discrepancy regarding the cause of death and actual death rate for our institution.

Attached are corrections to the HCFA data only.

Sincerely,

Luella Rill

Luella Rill
Vice President

LR:am

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

The Jewish Federation of Metropolitan Chicago
A Permanent Affiliate of
Schwab Rehabilitation Center
A Teaching Associate of
Rush-Presbyterian-St. Luke's Medical Center

Mount Sinai
Hospital
Medical Center

California Avenue at 15th Stre
Chicago, Illinois 60608

CORRECTIONS TO HCFA MORTALITY DATA LIST 1986

p. 1

[redacted] patient was in-house 12/10/86 through 12/25/86 (not 12/12/86); expired in hospital 12/25/86.

[redacted]: admission listed 5/4/86 through 5/16/86 should be excluded as it is the second to last admission; and 5/31/86 through 6/1/86 be included as patient expired in hospital on 6/1/86.

p. 3

[redacted] admission listed 7/ 2/86 through 7/14/86 should be excluded as it is the second to last admission; and 7/18/86 through 7/18/86 should be included as patient expired in hospital 7/18/86.

[redacted]: admission listed as 7/30/86 through 8/12/86, expired 7/31/86; but patient was here 7/19/86 through 7/30/86 on the psych unit, 7/30/86 through 8/12/86 on a med unit, and was discharged alive on that date to a Nursing Home. Patient was again seen in ER 8/27/86 and was again discharged alive to a Nursing Home.

p. 5

[redacted]: admission listed 12/22/86 through 12/31/86 should be excluded as it is the second to last admission; the patient was here again 1/2/87 through 1/18/87 and expired on that date. Although the patient expired within 30 days of the 1986 admission, shouldn't this be counted as a 1987 death?

[redacted] date of death is incorrect; should be 1/16/86 instead of 1/20/86; patient expired in hospital.

NORTHWEST
COMMUNITY
HOSPITAL

800 West Central Road
Arlington Heights, Illinois 60005
312-259-1000

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P. O. Box 26676
Baltimore, Maryland 21201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for 1986. Northwest Community Hospital's staff has reviewed the data to determine its validity and accuracy. In general, we have found the data to be valid, with minor exceptions.

To give you a framework for understanding our response, our hospital is a 420 bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full service medical center offering care in specialty areas of oncology, major orthopedic services, psychiatric care, as well as general medicine and surgery.

Our Hospital believes that evaluating the overall quality of care can only be achieved by reviewing a broad range of clinical and management factors. Looking at an individual factor in isolation of the others would not be an accurate reflection. After a careful critique of all the factors, Northwest Community Hospital strives to make corrective actions whenever we stray from our patient care goals and objectives. Mortality data is one factor our Hospital uses in the review of quality care.

Mortality review is an ongoing process of our quality assurance program. The Medical Staff at Northwest Community Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. However, mortality information is not, in itself, a measure of hospital performance. At best it can be used to focus quality assurance activities and to provide one indicator for improving management of our patients. These mortality data statistics alone are not adequate to base or judge the quality of care provided by hospitals. We hope this important point is made clear to the media who will report the information.

Thank you for the opportunity to present this response.

Sincerely,

Malcolm D. MacCoun
President

An affiliate of Central Health Care Corporatio

Northwestern Memorial Hospital

Superior Street and Fairbanks Court
Chicago, Illinois 60611
312/908-2000

October 27, 1987

Medicare Provider #: 14-0281

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 309-G
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C.

Dear Mr. Roper:

Northwestern Memorial Hospital has received and reviewed the mortality data provided by the Health Care Financing Administration (HCFA). We welcome this opportunity to provide comments. The report indicates Northwestern Memorial's mortality rates are within predicted ranges across all diagnostic categories. While we are pleased with these results, we have serious reservations regarding any attempt to equate the findings to a measure of hospital performance or quality.

The data used by HCFA indicates that a total of 377 Medicare patients admitted to Northwestern Memorial Hospital died within 30 days of admission. A review of this data identified numerous variances. We have attached a corrected copy to assist HCFA in clarifying data discrepancies. The corrections indicate data used by HCFA does not readily match with Northwestern Memorial Hospital data. The nature of the corrections are as follows: 1) four patients included in our data were not treated at Northwestern Memorial Hospital; 2) two patients HCFA lists as expired at discharge were actually discharged alive; 3) different dates of expirations were indicated for two patients; and 4) some patients had social security numbers that Northwestern Memorial links with live males rather than expired females. Overall, at least 94 patient data variances are noted.

Eighty-eight of the 377 patients HCFA had identified expired subsequent to their hospitalization. Verification of data for this patient group would have necessitated contacting patient families, a method which Northwestern Memorial deemed inappropriate at this time.

An Affiliate of the Northwestern Memorial Corporation
Member of the McGaw Medical Center of Northwestern University

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

The HCFA data, when taken in isolation, does not measure hospital quality or performance. The model used to predict mortality rates has not been validated, and as noted before, no peer review of the information has occurred. Many diagnostic categories have less than 100 patients which makes them statistically questionable. The model does not incorporate a measure for severity, a statistic which the government itself has recognizes is lacking in the prospective payment system based on Diagnostic Related Groups.

More importantly, the model excludes key characteristics which affect predictions or estimates of the likelihood of death. For Northwestern Memorial, these include: 1) more complex cases associated with being a teaching hospital and tertiary care referral center, 2) designation as a trauma center by the City of Chicago and 3) operating specialized care programs such as being a federally designated cancer center and engaging in organ transplantation.

Northwestern Memorial has demonstrated and is committed to high quality care and service for our patients. We have in place a comprehensive quality assurance program which addresses a variety of quality issues including adverse outcomes such as mortality.

We will be pleased to work with all legitimate agencies and purchasers including HCFA to enhance the quality of services available to all people.

Again, thank you for the opportunity to comment.

Sincerely,

Gary A. Mecklenburg
President
Northwestern Memorial Hospital

GAM/dw

cc: Mr. Charles T. Brumback
Chairman, Board of Directors

Dr. John H. Sanders, Jr.
Chief, Medical Staff

Ms. Carol M. McCarthy
President
American Hospital Association

NORWEGIAN
AMERICAN
HOSPITAL

1044 N. Francisco Ave.
Chicago, IL 60622
312/278-8800

CHAIRMAN
Norman R. Dahl

VICE CHAIRMAN
Chris C. Johansen

SECRETARY AND COUNSEL
Elmer E. Abrahamson

IMMEDIATE PAST PRESIDENT
Joseph J. Sommer

TRUSTEES
Arthur Bagge
Robert Baker
Barry G. Bollinger
Saul R. Barkin
Robert B. Bolt
Judge Henry A. Budzinski
John B. Cavenagh, M.D.
Harvey P. Cleven
Raymond DesRosiers, M.D.
Victoria Elliot, M.D.
Willard P. Engelhard
Irving Highland
Fred A. Luecker
James N. O'Connor
Edward C. Prest
Alan I. Rubens
Pablo Zalduendo, M.D.

HONORARY TRUSTEES
Larsandrew Dolan, M.D
William Leyhe
Stanley M. Sorensen

PRESIDENT
Michael H. Sussman

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Hubert H. Humphrey Bldg.
200 Indenpendence Avenue Southwest, Room 314G
Washington, D.C. 20201

Dear Doctor Roper:

Thank you for the opportunity to comment on the hospital mortality information the Health Care Financing Administration plans to publish in December. The Director of Medical Records has validated that the data for Norwegian-American Hospital is accurate. However, we wish to include the following information in the December publication.

Norwegian-American Hospital is a 253-bed acute care facility. Our case mix includes patients with major medical illnesses. We are a full service health care facility offering services in the areas of Obstetrics/Gynecology, pediatrics, internal medicine, surgery, geriatrics, intensive care, and emergency services. In addition, we operate a state-of-the-art Level II Nursery and a newly renovated Labor/Delivery/Recovery unit.

The Medical Staff of Norwegian-American reviews the medical record of every patient who expires at this facility for appropriateness of care. Mortality review is an ongoing part of the Quality Assurance Program. The Joint Commission for Accreditation of Healthcare Organizations has given Norwegian-American a full 3-year accreditation.

Our review of the mortality information tabulated by HCFA indicates that of the patients included in the data:

- 74% were transferred to Norwegian-American directly from other health care facilities and, of these, 69% were transferred on an emergency basis,
- 15% of the patients did not die while in the hospital,
- 74% of the patients were 71 years of age and over, the majority of which suffered from several illnesses,
- Norwegian-American's actual mortality rates did not exceed the range of predicted mortality rates.

Of note, the HCFA mortality data selects only the patient's primary diagnosis and principle procedure as the guide for categorization, but omits the actual cause of death as well as the patient's associated morbidities. Nevertheless, the Hospital shall incorporate HCFA's mortality data as one component of its comprehensive, retrospective quality of care reviews and continue to review all mortality cases for quality and appropriateness of care.

Sincerely,

Michael H. Sussman
President and Chief Executive Officer

Norwegian-American Medicare Provider #140206

Oak Forest Hospital

15900 South Cicero Avenue • Oak Forest, Illinois 60452 • Phone: (312) 687-7200 • Chicago: (312) 928-4200

October 22, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Medicare Provider # 14-0298

Dear Dr. Roper:

As the only licensed and accredited Chronic Disease hospital in Illinois and one of a small number in the United States, I feel a obligation to respond to the mortality information compiled by HCFA regarding Oak Forest Hospital.

After close review and scrutiny of your agency's data, by our Quality Assurance Committee and Medical Staff, Oak Forest Hospital concurs that 251 Medicare patients died within 30 days of admission to our acute facility. Of this number, 230 persons died while still a patient in the acute facility while 21 expired anywhere from 1 to 24 days after discharge.

Admittedly, in 6 of the 15 diagnostic categories, HCFA's "actual mortality rate" falls outside the range of "predicted mortality rates" established by your agency. Oak Forest Hospital does not dispute these figures but asks only for an opportunity to explain WHY the data might paint a distorted picture of our quality medical center.

Our 1,000 bed facility has a unique mission in comparison to most of this nation's hospitals. Oak Forest Hospital provides care, treatment, and rehabilitation to persons who suffer from chronic illness, degenerative diseases, and physical impairments. Four "levels of care" are available to our patients: acute, chronic disease, intermediate care, and comprehensive rehabilitation. As you can see from review of our mission statement, Oak Forest Hospital treats unusually large numbers of severely ill patients.

How are these patients admitted or referred to Oak Forest Hospital? Our facility has gained a glowing reputation in the Chicago area for providing high quality, cost effective long term health care for persons without regard to a patient's ability to pay. Therefore, over 100 hospitals and 40 nursing homes in the Chicago metropolitan area refer patients to Oak Forest Hospital for progressive medical services, continuing care in one of four levels, and compassionate treatment.

Yes! Oak Forest Hospital is a <u>referral</u> hospital which admits patients that are much sicker than those admitted to a community hospital.

It is unfortunate that HCFA's methodology neglects to include such measures of severity. When the public examines HCFA's data they cannot see that our patients were severely ill at the time of admission or transferred from another hospital or nursing home.

One therefore, cannot dispute why Oak Forest Hospital has experienced a "higher than predicted mortality rate" in 6 diagnostic categories as estasblished by your agency. These "higher than predicted mortality rates" are in no way an indication of poor quality care! Our patient population consists of a great number of medical cases where the anticipated outcome is death.

The Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities attest to the high quality of patient care available at Oak Forest Hospital. Governed by the Cook County Board of Commissioners, our facility maintains certification by these two prestigious organizations.

Attached to this letter of comment you will find a medical review of those diagnostic categories where HCFA determined through faulty methodology that Oak Forest Hospital is over the range of predicted mortality. It is my hope that HCFA will publish this review in order to lessen any disservice done to the public due to limited information released by your agency.

Oak Forest Hospital agrees with HCFA's position "that the information (mortality rates) on its own is not a complete measure of the quality of care at an individual hospital. While we believe that information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals."

HCFA has also been advised at length of the flaws associated with this study of mortality data. Your agency has an obligation to the public. They must be adequately informed that the mortality rates apply only to Medicare patients and differ from other indicators of inpatient mortality because they are calculated using only deaths that occurred within 30 days of the last admission of a Medicare beneficiary to a hospital during 1986.

Oak Forest Hospital shares the viewpoint with HCFA that hospitals must maximize the quality of care provided to their patients. Our medical center is aware that the American Hospital Association and the Joint Commission on Accreditation of Healthcare Organizations continue to investigate methods of evaluating hospital quality that rely on measures other than mortality rates. Oak Forest Hospital looks forward to the results of their efforts. Hopefully, your agency will benefit from their expertise.

We ask that you do not mislead the public. These flaws are most evident when your agency uses built-in biases like the 30 day post-admission mortality rates as an indicator of quality of patient care. Within 30 days of admission

to an acute hospital a patient could die for a reason unrelated to his treatment. What about the patient who was admitted to the hospital for eye surgery but died 25 days later of a heart attack or accidental death outside the hospital?

Our medical center is fully committed to monitoring quality of care through various medical committees comprised of experienced health care professionals. These committees meet on a regular basis and include: Utilization Review, Infection Control, and Pharmacy and Therapeutics and hospital-wide Quality Assurance committees. Through ongoing cooperative efforts with regulatory (PRO) and voluntary agencies (JCAHO and CARF), Oak Forest Hospital continually attempts to prevent problems from arising.

In closing, Oak Forest Hospital feels strongly that quality of care judgments can only be made after close review of the information contained in the patient's medical record. However, we appreciate the opportunity to address these critical issues raised by your organization. Perhaps in the future, more acceptable quantifiable methods of determining quality patient care will emerge.

Sincerely,

Edmund G. Lawler
Director

EGL/mh

Addendum

Oak Forest Hospital

15900 South Cicero Avenue • Oak Forest, Illinois 60452 • Phone: (312) 687-7200 • Chicago: (312) 928-4200

MEDICARE PROVIDER #14-0298
ADDENDUM TO OAK FOREST HOSPITAL COMMENTS REGARDING HCFA MORTALITY DATA

Oak Forest Hospital conducted a preliminary medical review or audit of the 6 diagnostic categories where HCFA categorized this Chronic Disease hospital as exceeding the range of their predicted mortality.

Upon review of a sample of these medical records, one realizes that the patients did not necessarily die from the principle diagnosis or illness for which they were admitted. These patients also suffered from an extensive variety of other serious illnesses which ultimately resulted in their deaths.

1. GC - GASTROINTESTINAL CATASTROPHES

The average or typical patient admitted to the acute facility for this principle DRG diagnosis is 75 years of age. The patient was admitted originally to Oak Forest Hospital's chronic disease unit from an acute care facility. The patient had been admitted on several occasions to another community hospital for illnesses such as stroke, pneumonia, or heart disease. He or she received care in our chronic disease unit for an average of 168 days. Because of past poor health, the patient developed feeding difficulties which resulted in the need for gastrotube feedings. The patient then developed a gastrointestinal hemorrhage and was admitted to our acute facility for a work up. The typical patient died before the work up was completed, within one to two days of admission to the acute facility.

The patient's principle diagnosis or reason for admission was upper GI hemorrhage. However the patient's actual cause of death can be shown as cardiorespiratory arrest secondary to acute myocardial infarct.

2. GU - UROLOGIC DISEASE

The average or typical patient admitted to the acute facility for this principle DRG diagnosis is 75 years of age. He or she was originally admitted from another acute hospital to our chronic disease unit for up to 60 days before being transferred to our acute facility. The patient was transferred to the acute facility due to a urinary tract infection and possible septicemia. These patients exhibited lengthy histories of long standing chronic disease such as stroke. After an average length of stay in the acute facility of 12 days, the patients died. However, the typical patient's cause of death was not his principle diagnosis, urinary tract infection. The cause of death can be attributed to cardiopulmonary arrest secondary to congestive heart failure.

3. HM - SEVERE CHRONIC HEART DISEASE

The average or typical patient admitted to the acute facility for this principle DRG diagnosis is 66 years of age. The patient was originally admitted to our chronic disease unit from another acute care facility. These patients generally receive care in our chronic disease unit for up

to 18 months. During this period, the typical patient developed several complications or co-morbidities such as pleural effusion or congestive heart failure. The progression of these various illnesses caused the physician to admit the patient to our acute facility. Patients stayed approximately 5.5 days in the acute facility before dying. The patients past history revealed other diseases such as cancer, renal failure, or hypertension. Certainly, the typical patient was admitted to the acute facility for congestive heart failure. However, the actual cause of death can be attributed to a disease such as cancer of the colon with metastasis to the liver.

4. HS - SEVERE ACUTE HEART DISEASE

The average or typical patient admitted to the acute facility for this principle DRG diagnosis is 72 years of age. He or she was originally admitted to our chronic disease unit from another acute care facility. The typical patient remained in the chronic disease unit for only 3 days before being admitted to our acute facility. Medical histories of these patients revealed stroke, diabetes, peripheral vascular disorders, myocardial infarctions, congestive heart failure, and arterial fibrillation. The typical patient remained in the acute hospital up to approximately 14 days before death. The typical patient's principle diagnosis and reason for admission is listed as cardio pulmonary arrest. However, closer investigation reveals that the cause of death was actually cardiopulmonary arrest due to pulmonary embolism.

5. ME - METABOLIC/ELECTROLYTE DISTURBANCES

The average or typical patient admitted to the acute facility for this principle DRG diagnosis is 72 years of age. He or she was originally admitted from another acute hospital to our chronic disease unit for an average of 249 days. The patients have experienced long standing histories of insulin dependent diabetes mellitus and multiple hospital admissions. Generally, these patients develop dehydration, electrolyte imbalance, and irreversible renal failure which results in death within 6 days of admission to our acute facility.

The typical patient's principle diagnosis is documented as prerenal azotemia with renal failure. However, the patient's actual cause of death can be attributed to cardiopulmonary arrest due to pneumonia.

OFH

6. PN-PULMONARY DISEASE

The average or typical patient admitted to the acute facility for this principle DRG diagnosis is 80 years of age. He or she was originally admitted to our chronic disease unit from another acute care facility. The patient received treatment in our chronic disease unit for an average of 38 days before being admitted to our acute facility. The typical patient's medical history shows recurrent cardiac problems, pneumonia, renal failure, and stroke. These patients generally develop pneumonia as a result of these multiple chronic debilitating conditions and die within 9.3 days of admission to the acute facility. The typical patient's principle diagnosis or reason for admission is listed as acute respiratory failure secondary to pneumonia. However, the actual cause of death is cardiopulmonary arrest secondary to pulmonary pneumonia.

We are confident that these typical examples will show the severity of illness experienced by the patients under our care. Once HCFA has developed additional statistical measures to deal with complex issues such as severity of illness, the agency's statistics cannot measure quality of care.

IL 162.5

PARIS COMMUNITY HOSPITAL
EAST COURT ST. • PARIS, ILLINOIS 61944
TELEPHONE (217) 465-4141

October 26, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

This letter is in response to the Health Care Financing Administration's intent to publish selected mortality information about Paris Community Hospital for Medicare patients treated at our hospital in 1986. We appreciate the opportunity to respond to the data being used because we feel that some information being presented is incorrect and the data presented in this format very misleading.

According to the HCFA data, of all the diagnostic catagories identified in the study, Paris Community Hospital is within the range of predicted mortality rates, with the exception of one, that being severe, acute heart disease. According to the data, there were seventeen cases identified with an actual mortality rate of 71%. However, in reviewing the medical records of all Medicare patients in that category, there were forty-four patients within that diagnostic category and the mortality rate was 27%. The range for that category is 19%-63%. Therefore, we are well within the range for this diagnostic category.

We would also like to comment on the manner in which the study itself is being presented. As Paris Community Hospital is a rural hospital, obviously, we treat fewer patients than the larger, urban hospitals. Therefore, whenever statistical inferences are made such as the study in question, it is very difficult to make statistical inferences with such a low volume of cases. Additionally, the range of predicted mortality rates is considerably vague, large, and in our opinion, insignificant. As an example, the range for gynecological disease is zero to 90%. How can any inferences be made with such a large range of predicted mortality rates?

Paris Community Hospital has a quality assurance program which functions quite well. Because we are a rural hospital and there are relatively few deaths, each death is reviewed in detail by several members of the Medical Staff. Therefore, it is our position that while the Health Care Financing Administration will make it clear that the information on its own is not a complete measure of quality of care at an individual hospital, many of the readers will interpret the results in a negative manner, when in fact, it is often times the data that is incorrect or misleading and not necessarily the quality of care provided at the hospital.

I do appreciate the opportunity to make comment on this study.

Sincerely,

Lawrence E. Wills

Lawrence E. Wills
Administrator

ktb

Perry
Memorial
Hospital

530 Park Avenue East • Princeton, Illinois 61356 • 815/875-2811

September 28, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

On behalf of Perry Memorial Hospital (hospital #140027), I appreciate being given the opportunity to comment on the mortality data for 1986.

First, let me say that our analysis of the data indicates that it is substantially correct.

Second, while the mortality rate revealed by the data is well within the ranges calculated, there are two important considerations about which the reader should be cognizant as it relates to moralities at Perry Memorial Hospital. The first of these is that during 1986 the area served by Perry Memorial Hospital suffered from acute shortage of skilled nursing beds. Consequently, many patients who would normally have been expected to die in a skilled facility were admitted to Perry Memorial. The acuteness of this situation reached such a point that in January, 1987, the hospital opened 10 skilled nursing beds.

The second area of concern has to do with the case mix index at Perry Memorial Hospital. Comparing Perry Memorial's case mix to other short term acute general hospitals in northern Illinois, our case mix index for Medicare patients is substantially above the average. In other words, it appears that this hospital treats "sicker" patients than hospitals with whom we might be compared.

My third main point, is that the HCFA data are not, in themselves, measures of hospital performance. At best, they can be used to better focus quality assurance activities in our hospital. Under no circumstances should they be used as a basis for judging the quality of care provided by different hospitals, regardless of the outcome

or the relationship between the hospital's specific data and the ranges developed.

Again, I appreciate the opportunity to comment on this data.

Yours truly,

William H. Spitler III

William H. Spitler III
President

Public Hospital of the Town of Salem

October 22, 1987

William L. Roper, M.D.
Administrator,
Department of Health & Human Services,
Health Care Financing Administration,
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for giving us an opportunity to review the data used to develop the mortality rates and ranges for our hospital.

We realize that in an exercise of this magnitude, it is possible that there may be errors in the data used to conduct the analysis. We appreciate you pointing out this possibility and giving us the opportunity to submit our analysis.

Please consider the following analysis of our data:

HOSPITAL = [redacted]

1. [redacted], was not a patient of our Hospital. [redacted] was a patient of St. Joseph's Hospital, Breese, Illinois.

2.	Diagnostic Catagory	Total Cases	Deaths	Actual Mortality Rate	Range of Predicted Mortality Rates
HFCA DATE	HS - Severe Acute Heart Disease	Admitted 15	11	73%	21 to 67%
Public Hospital of the Town of Salem Data		27	10	37%	"
3. HFCA DATA	RN - Renal Disease	03	02	67%	04 to 85%
PHOTOS DATA		05	02	40%	"

	Diagnostic Catagory	Total Cases	Deaths	Actual Mortality Rate	Range of Predicted Mortality Rates
4.		Admitted			
HFCA DATA	SE - Sepsis (Septicemia)	03	02	67%	06 to 87%
PHOTOS DATA	SE - Sepsis (Septicemia)	06	02	33%	"

5. We have attached copies of our UB 82's to substantiate our analysis.

We are a small rural acute care hospital and take pride in recognizing that we need to stabilize some patients and transfer them to a tertiary hospital. We trust that you have taken this into consideration.

Thank you again for allowing us the opportunity to submit our analysis.

Sincerely,

PUBLIC HOSPITAL OF THE TOWN OF SALEM

Harriet M. Hardacre

Harriet M. Hardacre,
Assistant Administrator

Ravenswood Hospital Medical Center
4550 N. Winchester • Chicago 60640 • (312) 878-4300

Caring . . . is what we do best

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administrtion
Department of Health and Human Services
Washington, D. C. 20201

Dear Doctor Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for January 1, 1986, through December 31, 1986. Since receiving the report dated September 21, 1987, Ravenswood Hospital Medical Center staff has had an opportunity to review the data.

Ravenswood Hospital Medical Center is a 462 bed non-profit, acute care community teaching hospital, whose case mix includes many patients with major medical and surgical illnesses. We are a full service medical center offering care in specialty areas of oncology, orthopedic services, rehabilitative medicine, coronary disease, dialysis, as well as general medicine and surgery.

The Medical Staff at Ravenswood Hospital Medical Center conducts an intensive review of the medical record of <u>every</u> patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance Program and peer review activities are an integral part of the monitoring of the healthcare delivery system at Ravenswood. The Joint Commission on the Accreditation of Healthcare Organizations has recently completed its survey of Ravenswood and gave this facility commendation for the hospital Quality Assurance Program and the peer review process.

The hospital specific mortality data reported by HCFA has been carefully reviewed by the hospital administrators, President of the Medical Staff, Physician Chairman of the Utilization Review Committee, Director of Utilization Review and Quality Assurance and the Director of Medical Records. We note Ravenswood Hospital Medical Center falls within the range of predicted mortality rates for all 16 diagnostic categories. We also note Ravenswood falls below the middle range of predicted mortality rates in 12 of the 16 categories while also falling below the middle range of the predicted mortality rates for all causes.

Board of Directors
David M. Murdoch
Chairman

Angelo Garoufalis
Vice Chairman

Marion Sitkiewicz
Treasurer

John Fairfield
Secretary

Maurice A. Colbert, M.D.
Assistant Secretary

Henry J. Kutsch
President

Edward Abraham, M.D.
Wallace Appelson, Ed.D.
Dorothy Ballman
William M. Bartlett
Henry O. Beard
Edward S. Bottum
William B. Browne
Brian Crowe
Lewis Ginsberg
Harry H. Hetz, M.D.
Thomas E. McGough
Marcelo Munoz, Jr., M.D.
R. Willard Nagle
Robert I. Nash
Daljeet Singh, M.D.
Paul Sobolewski
Bide L. Thomas
Stanton W. Todd, III
David L. Verduin
Richard G. Walker
Cyril Wiggishoff, M.D.

Honorary Directors
Harry Carter, M.D.
Maurus T. Goetz
George S. Hoban
George Hathaway
Honorary Chairman of the Board

Life Directors
Edwin C. Burmeister
J. Robert Newgard

Affiliated with the University of Illinois College of Medicine

VHA
Affiliate of Voluntary Hospitals of America, Inc.

We recognize along with the Health Care Financing Administration the mortality data is not a complete measure of quality of care at an individual hospital. Consumers of health care should be able to take into consideration other aspects which measure the quality of care delivered. Some of those considerations are whether a comprehensive quality assurance program for each department within a hospital is in place, whether there is an on-going medical education program for both resident physicians and other health care professionals, whether the facility is a teaching hospital, whether strict requirements for medical staff membership are in place, i.e., board certification of medical staff members, and whether the facility has a favorable autopsy rate.

There are obviously many considerations in measuring the quality of care delivered by hospitals. We look forward to the further development of additional statistical measures to deal with complex issues such as severity of illness and other aspects surrounding quality of care.

Sincerely,

Henry J. Kutsch
President

HJK:sh

Resurrection
Hospital

7435 West Talcott Avenue Chicago, Illinois 60631 312-774-8000

October 27, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Health Standards in Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, Maryland 21207

RE: Resurrection Hospital Mortality Data -- Hospital ID #140117

Dear Doctor Roper:

Thank you for giving Resurrection Hospital the opportunity to comment on HCFA's mortality data. We have reviewed the information which you have given to us and have the following comments:

1. While there are some individual discrepancies with age of patient, date of discharge and date of death, on the list provided by you, we feel that the information presented to us was substantially accurate. During 1986, 6,842 Medicare patients were admitted to Resurrection Hospital. Our records indicate that a substantial amount of our admissions come from Medicare patients.

2. HCFA's data indicates that a total of 597 Medicare patients admitted to Resurrection Hospital died within 30 days of admission. Of these, 491 died while a patient at our hospital; 106 people died outside the hospital.

3. Of the identified categories, Resurrection Hospital's actual mortality rates were well within your ranges in all cases. We feel that this reflects the age, stage of illness, and severity of the patient's illness at the time of their admission.

We welcome the opportunity that you have presented to us to review this data prior to its publication. As has been pointed out by many others, mortality is not the only indicator of the quality of care offered by an institution. We do feel that the care that we offer patients is of the highest quality and that we can be proud of it. Should you have any questions, please feel free to call me. Thank you.

Sincerely yours,

Sister Bonaventure, CR

Sister Bonaventure, C.R.
President

SBCR/mc

Richland Memorial Hospital

October 23, 1987

William L. Roper, M.D. - Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to your agency concerning the recently distributed mortality information from short term, acute care hospitals.

The staff of Richland Memorial Hospital was pleased to see that its statistics were well within the expected ranges published by HCFA. We were also pleased to see the much improved data insofar as accuracy and completeness in comparison with the data released in 1986. We were also pleased that we would have an opportunity to review the data and point out errors or other problems. Incidentally, we found a very small number of errors. The data can be very helpful, as pointed out in your cover letter, for identifying areas for review of quality of care concerns. We will use the present data in that light and will continue this practice with future data releases.

We have several areas of concern, however. The publicized purpose of the data release is for a review of deaths and an opportunity to evaluate quality of care implications. It is important to recognize that Richland Memorial Hospital, as well as other hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations, have carried out this type of review for a number of years.

There is no question but what the analysis of data relating to any particular series of events yields valuable information which can improve the handling of circumstances surrounding future events. Release of data on such an important issue as mortality requires sufficient education and preparation for those who will be reviewing the data with the most interest. We are, however, unaware of any effort to educate the general public about this data and its significance. In other words review of this data by the general public can result in significant misunderstanding without prior education on this issue.

800 East Locust, Olney, Illinois 62450 AC 618-395-2131

I encourage your agency to review the circumstances under which data is released and insure that at least as much time is given to educating the public about the analysis and interpretation of the data as is given to the publicizing of the data itself. In this way, the data can truly serve as an educational tool for the public in making their healthcare decisions.

The methodology on the development of the data causes us concern. The information shows the last place of hospitalization prior to death, without consideration of whether the death was related to the reason for last hospitalization. The methodology also allows no room for the fact that 37 of the 129 Medicare deaths occurred at a location other than Richland Memorial Hospital. To further complicate the issue, the cause of death on each of these is unknown. Therefore, we are unable to analyze the implications insofar as quality of care at RMH.

Of the deaths which did occur at Richland Memorial Hospital there were various causes, patient situations, etc., including circumstances where the patient chooses no extraordinary measures. Moreover, the data does not reflect the fact that in most of the patients there were multiple causes of death due to the age and disability of the individuals. It is also significant that the average age of the patients who died was 78. So, in many cases, the death was not unexpected or, in some cases, where extraordinary measures were specifically refused, death was fully expected by the patient.

In addition, it is our understanding that the original purpose of the data collection was to compile data for review by the professional standards review organizations. Certainly data from a 20-30 county area would allow valid statistical analyses. It is doubtful that the data from 6-8 counties (the Hospital's service area) allows for statistically valid analyses.

Thank you very much for the opportunity to review the data.

Sincerely,

Harvey H. Pettry
Administrator

kmj

Robert G. Miller
president

350 north wall street
kankakee, illinois 60901
(815) 933-1671

Riverside medical center

October 22, 1987

Medicare Provider
Number 140186

William L. Roper, M. D.
Administrator
Health Care Financing Administration
6325 Security Building
Baltimore, Maryland 21207

Dear Dr. Roper:

Riverside Medical Center appreciates the opportunity to comment on the 1986 Mortality information sent to us. In addition to the limitations to this data, as acknowledged by your agency, we have several concerns which are described below.

The data used by HCFA indicates that a total of 1,641 Medicare patients were admitted to Riverside Medical Center. Of these, 145 died while still a patient of the hospital, while 38 died after discharge. Our records indicate that 2,759 Medicare admissions occurred at Riverside Medical Center in 1986. The numbers published by HCFA suggest an under reporting of the Medicare patients treated at Riverside Medical Center. This under reporting would obviously cause an inflated mortality rate for the hospital. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

No allowance has been made for severity of illness within diagnosis or number of patients. The review of our data reflects that the average age of Medicare patients who died is 78 years. Appended to the end of this letter is a table that reflects the average age of Medicare patients who died categorized by diagnostic category. In addition to this high average age, our review of the patient's conditions reflects multiple significant chronic illnesses.

It is important to note that Riverside Medical Center has the largest specialty-based cancer service in our area. This service attracts a significant number of patients who suffer a terminal illness. This service continues to see an increasing number of patients due to its reputation as a high-quality, compassionate medical service.

Board of Trustees

Howard Gordon
Chairman

Larry R. Taggart
Vice Chairman

Robert G. Miller
President

Sharon L. Corzine
Secretary

David H. Schroeder
Treasurer

Ronald Cauley
Richard Hess, D.D.S.
Charles C. Huber
Kenneth Johnston, M.D.
Shirley Matheny
John W. McBurrows
Jon J. Peterson, M.D.
James G. Schneider
Charles H. Smith
Roger Taylor, M.D.
Wesley E. Walker
Evelyn L. Weiner

A Medical Leader. A Center of Caring

Riverside Medical Center shares the concerns of the health care industry in pointing out the shortcomings of the release of this information. These include:

1) The serious limitations of the probability model utilized coupled with the fact that it has not been validated. Statistical analysis of mortality rates can do no more than screen information for further review.
2) The lack of prominently displaying the qualifications to this data can lead to inappropriate interpretation of the data by the public.
3) This release of data has circumvented the peer review process - a process clearly endorsed by both the government and the industry as the accepted means by which to review the quality of care provided.

We endorse the federal government's efforts to work with the industry to more clearly identify quality of service indicators. However, this attempt can be used only as a basis for further study and in no way should be presented to the public as a definitive indication of quality of service provided by hospitals. We encourage the continued cooperative efforts established with the American Hospital Association and state associations to work in a cooperative manner to pursue our common goal of high-quality health care services.

Sincerely,

Robert G. Miller
President
Chief Executive Officer

slc/BBS7

Diagnostic Category	Average Age
Cancer	75
Cerebrovascular Accidents	80
Gastrointestinal Catastrophes	81
Gastrointestinal Disease	86
Urologic Disease	81
Gynecologic Disease	--
Low Risk Heart Disease	81
Severe Chronic Heart Disease	77
Severe Acute Heart Disease	79
Metabolic/Electrolyte Disturbances	77
Orthopedic Disorders	71
Pulmonary Disease	75
Renal Disease	85
Sepsis	86
Severe Trauma	85
Ophthalmalogic Disease	--
Other Diagnoses	79
All Categories	78

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION

ROCHELLE, ILLINOIS 61068
Telephone (815) 562-2181

Oct. 23, 1987
Provider number: 140038

Dear Dr. Roper,

In response to the Health Care Financing Administration's mortality data, I wish to address the following concerns:

1) The total number of deaths listed for Rochelle Community Hospital is 43. However, only 28 patients actually died while in our facility. It is difficult to accurately determine a cause and effect relationship between the prior discharge from this facility and the subsequent death within thirty days of discharge.

2) Two patients died within our facility from Sepsis. Our actual mortality rate for this diagnosis becomes 100% with our range of predicted mortality between 3% and 91%. I do not feel two cases present viable data nor is it statistically sound to predict a range of mortality rates based on two cases.

3) While I can understand and appreciate the value of such data for hospital Quality Assurance and Risk Management programs, I do not feel the public will fully comprehend such information. Mortality data could be misunderstood leading to confusion and apprehension among medicare beneficiaries and the general public.

4) HCFA mortality rates alone do not provide for factors such as measuring quality of care, performance standards, and severity of illness.

ROCHELLE COMMUNITY HOSPITAL ASSOCIATION

ROCHELLE, ILLINOIS 61068
Telephone (815) 562-2181

5) I fear publication of such sensitive information will be detrimental to those families of the deceased and may cause further liability concerns for the health care facility.

Sincerely yours,

Robert G. Knapp

Robert G. Knapp
Administrator

RFK/plw

2400 NORTH ROCKTON AVENUE • ROCKFORD, ILLINOIS 61103 area code 815/968-6861



October 22, 1987

William L. Roper, M.D.
Health Care Financing Administration
Department of Health & Human Services
Room 309-G, Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Rockford Memorial Hospital, Rockford, Illinois, (Medicare Provider Number 14-0239) is in receipt of the HCFA selected mortality data for Medicare patients during calendar year 1986. The system for maintaining patient care statistics at this, and I believe, most other hospitals is based upon discharge. Hence, it is not possible for us to precisely replicate, for purposes of a verification analysis, the population of Medicare patients admitted, treated, and who expired within thirty days of admission---the definition of Medicare billed patients utilized by HCFA for the mortality study undertaken. Nevertheless, our own internal procedures for the review of patient mortality would generally confirm the statistical accuracy of the mortality rates reported for the sixteen high and low risk medical conditions studied.

Despite that general congruence, we would call specific attention to certain discrepancies revealed through name by name analysis of the medical records for those individuals identified on the list supplied us. Those discrepancies include eleven cases qualified as in-house deaths which were listed by HCFA as post-discharge deaths and an additional case which appears on HCFA's list as a post-discharge death. The latter patient was re-admitted in 1987 and expired in-house on that admission. These discrepancies are further detailed in Attachments A & B.

On a more general note, we applaud HCFA's recognition and intended public disclaimer that the mortality information supplied to us and intended for public release does not provide a definitive assessment of quality care. We would agree that further refinements of the statistical procedures will be needed to incorporate indices of severity of illness in a manner that properly identifies those institutions whose special services (such as oncology or cardiac surgery) or whose designation as regional center (such as Renal Dialysis) finds them admitting and treating more severely ill patients--patients whose prognosis is more likely death in a statistical sense. For example, in an examination of our own data on patient mix utilizing Susan Horn's Severity of Illness Rating System, Rockford Memorial Hospital's patient mix is more typical of a University Teaching Hospital than a community hospital when one considers level 3 and 4 cases--those most at risk of death.

Rockford Memorial Hospital is a teaching unit of the University of Illinois College of Medicine in Rockford (UICOM-R). As such, the Hospital has long conducted careful and formal review of all mortalities. Such is a primary function of all Departments of the medical staff--a professional review process designed to monitor and most important, improve the quality of care. It is viewed as an essential tool in a successful teaching program.

Thank you for providing us with the mortality data for Rockford Memorial Hospital and for welcoming and publishing our comments.

Most Sincerely,

H. W. Maysent

H. W. Maysent
President

HWM/jc
Attachments

ATTACHMENT A

Rockford Memorial Hospital

Eleven cases qualified as inhouse deaths which were listed by HCFA as post-discharge deaths. This was due to incorrect HCFA date of death or date of discharge. The cases identified are as follows:

Patient ID Number (HIC)	Patient Name	Diag. Categ.	Date of Adm.	RMH date of disch.	HCFA date of disch.	RMH date of death	HCFA date of death
[redacted]		CA	08/07/86	08/24/86	08/24/86	08/24/86	08/25/86
		CA	10/21/86	10/24/86	10/24/86	10/24/86	10/27/86
		CA	09/08/86	09/22/86	09/22/86	09/22/86	09/23/86
		GC	12/02/86	12/19/86	12/19/86	12/19/86	12/22/86
		GU	09/16/86	09/16/86	09/16/86	09/16/86	09/17/86
		HL	02/27/86	03/04/87	03/04/86	03/04/86	03/07/86
		HM	10/18/86	10/19/86	10/19/86	10/19/86	10/31/86
		HM	04/16/86	04/23/86	04/23/86	04/23/86	04/24/86
		HS	12/08/86	12/08/86	12/08/86	12/08/86	12/11/86
		UN	05/05/86	05/28/86	05/12/86	05/28/86	05/28/86
		UN	11/25/86	12/14/86	12/14/86	12/14/86	12/15/86

Note that one additonal case appears on HCFA's list as a post-discharge death. However, the patient was readmitted in 1987 and expired inhouse on that admission:

		Admitted	Discharged	Expired
[redacted]	HM	12/11/86	12/24/86	
"	HM	01/02/87	01/05/87	01/05/87

ATTACHMENT B

Worksheet 1: Analysis of Reporting Errors

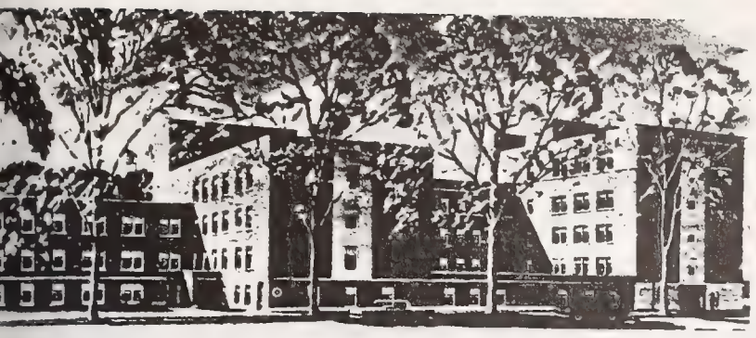
Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	46	22	49	19
CE -- Cerebrovascular Accidents	19	6	19	6
GC -- Gastrointestinal Catastrophes	7	3	8	2
GI -- Gastrointestinal Disease	8	5	8	5
GU -- Urologic Disease	1	2	2	1
GY -- Gynecologic Disease	1	0	1	0
HL -- Low Risk Heart Disease	17	4	18	3
HM -- Severe Chronic Heart Disease	28	6	31	3
HS -- Severe Acute Heart Disease	49	5	50	4
ME -- Metabolic/Electrolyte Disturbances	2	2	2	2
OP -- Orthopedic Disorders	1	3	1	3
PN -- Pulmonary Disease	28	10	28	10
RN -- Renal Disease	9	2	9	2
SE -- Sepsis	6	3	6	3
TR -- Severe Trauma	0	4	0	4
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	55	26	57	23
Total -- All Categories	277	103	289	90

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

We cannot identify Gallag (HIC 0037273711) as a Rockford Memorial patient; however, Kuntzelman is listed one line below with the identical information, including the same HIC# of 0037273711. Hence, our total is 379 versus HCFA's total of 380.

R. Weltmyer

IL 182.3



TELEPHONE (312) 995-3000

Roseland Community Hospital Association

45 WEST 111TH STREET • CHICAGO, ILLINOIS 60628

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Attention: W. L. Roper, M.D.

Dear Doctor Roper:

In principle, HCFA's objective to educate the health care consumer is a very worthwhile endeavor. Informed health care consumers make the best patients because the management of patients' treatment plans pivote around the patients' willingness to participate in the decisions that affect their individual health care.

When the hospital mortality rates are released in December of this year, HCFA states it will make it clear that this information, on its' own, is not a complete measure of the quality of care at an individual hospital. Nevertheless, despite its' limitations, HCFA states the information will be useful to a wide range of groups and individuals.

We at Roseland Community Hospital (RCH) wish to point out, however, that if HCFA takes on the responsibility of disseminating this information, then HCFA must also ensure this information is an accurate measure of what they say it can measure. Can mortality rates measure the quality of the care provided to patients? If a patient receives every appropriate service in a timely, efficient, and skilled manner, yet expires, does this mean quality of care was not provided? Conversely, if a patient receives inappropriate and suboptimal care during their hospital stay, yet leaves the institution alive, is it fair to imply that quality of care was provided? It is our contention that mortality rates cannot and do not measure the quality of care provided to a patient.

While it is important that each death be studied by the medical staff to see if and how it might have been postponed, the use of a statistic without mention of the complex factors that need to be weighed in this type of evaluation is irresponsible. Also, many outside factors, beyond the control of the health care provider, can impact greatly on the outcome for a particular hospitalization. For instance-

How soon did the patient seek treatment for a condition?
If a patient arrested, how soon was CPR initiated?
What was the initial health status of the patient?

Are there other co-morbid conditions present?
Was the patient compliant in adhering to the physician's treatment plan?
Were prescribed medications taken appropriately upon discharge?

These factors, as well as others, can have an immense effect on the outcome of a particular hospitalization.

We at RCH would also like to question your statistical methodology.

1) HFCA chose to focus on only some ICD-9-CM codes or DRG categories, 16 diagnostic categories in all, to the exclusion of all other possible causes of death. What is the purpose in studing only selective causes of death?

2) The use of only Medicare patients, which are predominantly composed of the elderly or sicklier patients, will quite naturally yield a higher than normal hospital mortality rate. The entire hospital population mortality rate should be examined, not just one payor class.

3) Including cases that fall within a 30-day post admission period allows inclusion of deaths in the hospitals' mortality rate for totally unrelated conditions. For example, a 78 year old woman expired in our emergency room of an acute myocardial infarction 18 days after she was discharged from our hospital for treatment of left hip pain. At the other extreme, patients who expired after the 30-day post admission period were not included in the comparative mortality data even though they had been treated from start to finish for the same diagnosis. Their deaths were excluded.

4) By choosing to include only the last admission of a patient, the cases identified have resulted in an oversampling of expirations as an outcome. This methodology is as flawed as if one would choose to look at only the next to last hospital admission which would result in zero expirations. Our point being, the manipulation of the parameters used to define your data collection can very easily manipulate the results that are attained.

5) By using only the last admission in 1986, it is very easy to manipulate the percentage rates cited in HCFA's "comparative mortality data." The number of Medicare deaths occurring at our institution in 1986 will remain a constant figure (the numerator) in the percentage calculation. The denominator will include only the <u>last</u> admissions for the 1986 period. No matter how successful your life-sustaining treatments were, only the last admission will be used to compute your mortality rate for 1986. This does not give a realistic picture of the mortality activity at our particular institution.

6) We would also like to take this opportunity to point out some errors that we found in our particular institutional data. In comparing your listed expirations with our death log, we have identified at least three cases which should have been included in your data. These expirations all fall within one of your 16 categories. Omission of these cases shows inaccuracy in your data collection, therefore, it tends to discredit your entire project.

In closing, we would like to reiterate that your goal to inform the health care consumer is very worthwhile. Yet, we feel the measure you have selected to present supports no useful information relative to the quality of care. This data will only be utilized to support a lot of inaccurate and unfortunate conclusions being drawn.

Respectfully submitted,

Corazon Benig, M.D.
President, Medical Staff

Jai Arya, M.D.
Chairman, Quality Assurance

Denise R. Williams
President

DRW/hf

cc: Otis R. Bowen, M.D., Secretary of Health and Human Services
Senator Alan Dixon
Senator Paul Simon
Congressman Daniel Rostenkowski
Congressman Gus Savage

RUSH NORTH SHORE MEDICAL CENTER
Rush-Presbyterian-St. Luke's Medical Center

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

In response to your letter of September 21, 1987, we have reviewed the HCFA mortality statistics relating to Rush North Shore Medical Center and have prepared the attached comments.

Sincerely,

Peter Butler

Peter W. Butler
President

PWB/jh
Attachment

9600 Gross Point Road • Skokie, Illinois 60076 • (312) 677-9600

Rush North Shore Medical Center
Skokie, Illinois

Comments Regarding HCFA Mortality Statistics

A review of the HCFA mortality data for Rush North Shore Medical Center (RNSMC), formerly Skokie Valley Hospital, reveals that RNSMC's actual mortality rates in 1986, for each of the 16 diagnostic categories and for all diagnostic categories combined, fall within the ranges of mortality rates predicted by HCFA. For seven of the diagnostic categories (gynecologic disease, opthalmologic disease, gastrointestinal catastrophes, orthopedic disease, metabolic/electrolyte disturbances, urologic disease, and severe trauma), RNSMC's actual mortality rates are very low compared with the predicted rates, falling in the lower quarter of the predicted ranges. The mortality rates for an additional six diagnostic categories (low-risk heart disease, pulmonary disease, and severe chronic heart disease) are at or below the midpoint of the predicted ranges.

Even though RNSMC's mortality rates are all within the ranges predicted by HCFA, there are several characteristics about the patients treated at RNSMC that are not taken into account by the HCFA model, but that do have a significant effect on the mortality rate at RNSMC for patients with various diagnoses:

Severe Acute Heart Disease

The HCFA model only considers a patient's last admission to an acute care hospital when it determines the hospital's actual mortality rates. If a patient is admitted to one hospital and then either transferred to a second hospital or discharged from the first hospital and later readmitted to a second hospital, the admission to the first hospital is not counted as an admission. In the case of heart disease, a significant number of patients with acute myocardial infarctions are either seen in the Emergency Department of RNSMC and transferred, or admitted to RNSMC and later transferred to another hospital for cardiac catheterization and/or cardiac surgery.

The patients who are transferred are typically healthier, more amenable to treatment, and less likely to die than are some of the patients who are not sent for cardiac catheterization or cardiac surgery. In the HCFA model, these healthier patients are counted as admissions to the second hospital, but not to RNSMC. Since these patients, who typically do not die within 30 days of admission, are not counted as admissions, the actual mortality rate at RNSMC will be higher than predicted by the model. It will also appear relatively high compared with the rate at facilities that perform cardiac catheterization and cardiac surgery. These facilities will both 1) have all of their "healthy" cardiac catheterization and cardiac surgery patients counted as admissions, and 2) will also benefit by having all the "healthy"

patients transferred to them for cardiac catheterization or cardiac surgery count as admissions. The mortality rate for heart disease at RNSMC will also appear relatively high compared with the rate of some more rural hospitals where these "healthier" patients are not sent for cardiac catheterization because it is not available in the area.

Cancer

RNSMC operates an Oncology Unit staffed with physicians and nurses experienced in the care of oncology patients. It offers an approach that recognizes the patients' total life style, primary care nurses to provide continuity of care, and support and involvement of families, as well as virtually all available treatment modalities. It does not, however, offer some of the highly specialized kinds of cancer treatments, such as bone marrow transplants, hyperthermia, and certain research protocols for chemotherapy, that are offered by a few major referral centers.

A certain number of cancer patients seek their initial hospitalizations at a referral center. Patients whose disease has progressed or those who cannot benefit from the highly specialized treatments offered by the referral centers, will more often choose to be admitted to RNSMC because of the excellent and very personal care that they receive.

Because the HCFA model takes into account only the patient's last admission in 1986, RNSMC's actual mortality rate will be higher than predicted by the model. It will also appear relatively high compared with the mortality rate of the referral centers. The referral centers will have admitted relatively few patients in the later stages of their disease and, therefore, will have a lower proportion of patients at risk of dying within 30 days of an admission. RNSMC's mortality rate will also appear relatively high mortality rate compared with hospitals in more rural areas where more patients are treated at their local hospital in the initial stages of their diseases, rather than traveling to a distant referral center.

Sepsis, Pulmonary Disease, Renal Disease, Metabolic/Electrolye Disturbances, Urologic Disease

RNSMC provides care to many patients who live in nursing homes. Nursing Home patients are generally sicker than patients of the same age living at home. Many have multiple chronic medical problems and they are often malnourished, dehydrated and bedridden. Some are demented and unable to participate and cooperate in their care. Others are depressed and no longer have the desire to eat properly or even to live. Because of their chronic medical conditions, nursing home patients are also more susceptible to acute infections, such as urinary tract infections and aspiration pneumonia. They also have a much more difficult time recovering from these infections. All of these factors tend

to make nursing home patients more at risk of dying than patients of the same age who live at home.

While age is taken into account by the HCFA model, whether or not the patient requires care in a nursing home is not. Since RNSMC admits a relatively large number of nursing home patients, its actual mortality rates for those diagnostic categories which are common reasons for nursing home patients to be hospitalized, such as those listed above, will be higher than predicted by the model. These mortality rates will also be relatively high compared with mortality rates of hospitals in areas of few nursing homes or in areas where nursing home patients are less apt to be transferred to a hospital just before they die.

As can be seen from the examples listed above, the HCFA mortality statistics have severe limitations. HCFA itself states that "we (HCFA) cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals." Many factors that influence the chance of death are not specifically included in the model. Some of these are severity of illness, stage of a progressive illness, underlying illnesses other than the eight types included in the model, effectiveness of treatment provided prior to the last admission, patient's general state of health, and family and other types of social support. Hospitals may serve a higher than average proportion of patients more at risk of dying because of the economic, ethnic, occupational or other nature of the patients living in the hospital's service area. Hospitals may also serve a disproportionately high number of patients prone to death because of the type of services it provides. The most obvious example of this would be a hospital that provides hospice service. The relative impact of each of these factors on death, its potential effect on a hospital's mortality rates, and the resulting inaccuracy of HCFA's predictions of mortality rates are not known.

Since many factors besides differences in the quality of care provided at a hospital may be responsible for differences between actual mortality rates and predicted rates and for differences in mortality rates between hospitals, the HCFA statistics cannot properly be used as a means to measure quality of care provided at a hospital. They can more appropriately be used to identify areas for further review.

RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER 1653 WEST CONGRESS PARKWAY, CHICAGO, ILLINOIS 60612

LEO M. HENIKOFF, M.D.
PRESIDENT

October 23, 1987

Mr. Harvey Brook
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Brook:

Rush-Presbyterian-St. Luke's Medical Center (Medicare Provider #140119) is grateful to the Health Care Financing Administration for the opportunity to review its statistics describing mortality experience at our institution. We have studied the data and find them reassuringly in the lower ranges although, as we hope to make clear, mortality experience is only one index of the quality of care a hospital provides.

Rush-Presbyterian-St. Luke's in Chicago is an Illinois not-for-profit corporation organized exclusively for charitable, scientific and educational purposes and governed by a voluntary Board of Trustees. It serves as the core of a comprehensive, cooperative academic health care delivery system designed to serve up to 1.5 million persons throughout Illinois and neighboring states. The major facility of the Medical Center is Presbyterian-St. Luke's Hospital, a 903-bed acute-care general hospital which cares for most patients referred to us from other hospitals. In addition, the Medical Center owns and operates Sheridan Road Hospital, a branch hospital with 125 licensed beds, and operates the Johnston R. Bowman Health Center for the Elderly, a geriatric care facility with 176 licensed beds. The Medical Center's academic component, Rush University, consists of four colleges. The Medical Center is active in community medicine through a number of programs many of which have been developed in specific response to the needs of the contiguous community. Because Rush is an academic tertiary care medical center which provides care in all areas of acute and chronic medicine, its mix of Medicare patients requires us to be one of

the most resource intensive institutions in Illinois to provide appropriate treatment. We provide state-of-the-art care in areas such as cardiovascular disease, open heart surgery, cancer, liver, bone marrow and kidney transplantation, orthopedic surgery, neurosurgery, and geriatric medicine, to name a few. Patients are often referred to us for care which cannot be provided at the community hospital level.

Our study of mortality data specific to our hospital has not identified any major problems with the quality of care provided or treatment rendered. More importantly, our respective clinical departments, regardless of payment source, conduct mortality reviews on a continuing basis. Findings from these reviews are used to recommend corrective action, if needed, and to educate the medical staff, when appropriate, in an effort to constantly upgrade patient care. It must be emphasized that a low mortality rate or absence of negative findings with respect to our mortality reviews in no way satisfies our commitment to the delivery of quality patient care services. To effectively evaluate patient care services, our quality assurance program employs many review mechanisms. These include, but are not limited to, infection control, drug therapy, blood usage and surgical case reviews. In addition, each clinical department is responsible for developing specific parameters to evaluate care rendered to all patients admitted under the service. Our commitment to providing quality care requires a continuous endeavor on our part to refine quality assurance methodologies and to seek opportunities to improve patient care.

Although the data disseminated by HCFA were largely verifiable, the meaning of these data is open to interpretation. Mortality, viewed in isolation, cannot be a measure of the quality of hospital care or of hospital performance. We would strongly encourage the use of additional parameters which provide a context within which mortality data can be better understood. These parameters might include the development of a severity index or the recognition of the expectations of the patients, family and physician upon admission. In the first case, the severity of a patient's condition may influence the likelihood of death. In the latter case, it may be the expectation of the patient, family and physician that the admission to the hospital is to be the terminal episode of the patient's life and is intended to provide the patient with an environment in which to die with dignity.

A final recommendation: We suggest that data verification by hospitals of HCFA mortality information would be greatly facilitated if HCFA could provide the patient's last name (in alphabetical order) and the admission date or the patient's medical record number. The medical record number would be the most appropriate mechanism to identify patients as it already appears on the Uniform Bill.

Sincerely,

Leo M. Henikoff, M.D.
President

LMH/mh

SARAH BUSH LINCOLN HEALTH CENTER
P.O. Box 372
Mattoon, IL 61938-0372
217/258-2525

RESPONSE TO HCFA MORTALITY STATISTICS

The Health Care Financing Administration (HCFA) has begun publishing mortality statistics to aid hospitals and health care consumers in evaluating the quality of care in their area hospitals. Using national data from a large number of hospitals, HCFA has established mortality parameters in several diagnostic categories of illness. Hospitals falling within the parameters are considered to have acceptable mortality rates. The 1986 mortality statistics, which were just released by HCFA, demonstrate that Sarah Bush Lincoln Health Center is well within the range of predicted mortality rates in every diagnostic category. We are especially pleased with this because the diagnostic categories established by HCFA use only Medicare data which reflects a segment of the population with a high proportion of illness and death.

HCFA provides this information for several reasons. The objective is that the data can aid hospital administrators, staff and physicians to maximize the quality of care provided to patients. HCFA also feels that this information will enable the public to make more informed decisions about their health care. While Sarah Bush Lincoln Health Center supports the concept of providing education for health care consumers, we are concerned about the measurements used by HCFA. Rather than informing and educating, these statistics may give the impression that hospital quality can be determined solely by the number of people who have died in the hospital or within 30 days of discharge. The only way to assess health care quality is on a case by case basis. By not taking into account the severity of illness, the timeliness of medical intervention and the availability of outreach health care services, HCFA fails to consider a wide range of factors with a significant impact on mortality. Examples include the patient's general health status, the stage of the patient's illness, the patient's psychological condition and family support.

We hope that if HCFA continues to publish this type of data, it can find a mechanism to more accurately communicate health care quality to the public.

SAVANNA CITY HOSPITAL

October 22, 1987

Health Care Financing Administration
Health Standard & Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, MD 21207

Dear Sirs:

First, let me comment concerning your study methodology. I find it incomprehensible that you would assign to a hospital, a mortality statistic that happens within a 30 day period after an acute, inhospital stay. The seeming multi-colinearity would negate the purposes of the data release. Also, by using the last admission date prior to death, the data seems to be skewed toward an overestimation of the probability that a hospital admission will result in death.

To address my hospital data directly, I will deal in the aggregate and then with major mortality categories. Savanna City Hospital is located in Carroll County, IL. This county has the largest percentage of over-65 residents, per capita of any county in Illinois. The average age of all Savanna City Hospital patients, included in the study, is 79.1; removing the only patient below age 65, brings the average age up to 80.3. We no longer deal with old age as a cause of death, but even HCFA calls it a co-morbidity and/or complication.

Of the 28 patients that fell within the parameters of the study, 15 patients were accepted from area nursing homes. There were six of these patients (40%) that were accepted in an unresponsive, cyanotic, semi-comatose condition. These types of transfers confound the mortality statistics that HCFA is releasing and has no bearing on the quality of care found at Savanna City Hospital.

Specifically, in the severe chronic heart disease category (HM), 51% of the patients were admitted in an unresponsive, semi-comatose, cyanotic condition that resulted in death within 24 hours. The more accurate mortality percentage rate is 19% rather than 44%. In the pulmonary disease category, one patient was admitted in a semi-comatose, cyanotic, unresponsive condition that resulted in death in less than 24 hours. The more accurate mortality percentage rate is 32% rather than the 37% rate shown. One patient in the renal disease category was admitted in a like condition with death resulting in slightly over 24 hours; the more accurate mortality percentage rate is 60% rather than the 80% figure shown.

Another 14% of the patients included in the study (with an average age of 89.5) were discharged to area nursing homes were they later expired. Therefore, the more accurate actual mortality rate for Savanna City Hospital is 15% and not the 23% figure shown.

Attention must, again, be redirected to the extremely high average ages of the patients included in the study. The average life expectancy in the United States is less than the average age of Savanna City Hospital patients included in the study.

Sincerely,

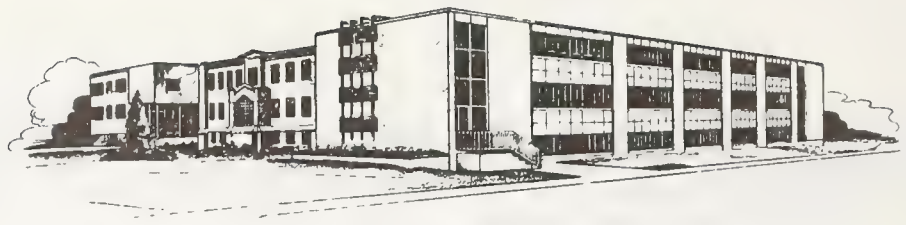
Jansen N Blanton

Jansen N. Blanton
CEO

JNB:vlk

enc.

GARLAND STROHL
Administrator



SHELBY MEMORIAL HOSPITAL
SOUTH FIRST AND CEDAR STREET • SHELBYVILLE, ILLINOIS 62565

26 October 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Attention: Dr. William L. Roper,
Administrator

Dear Doctor Roper:

In response to the mortality data information which will be released to the public and as particularly pertains to our hospital, I wish to offer the following response.

In this community most patients who suffer from a diagnostic category of cancer and enter our hospital are known by themselves and/or family members to be terminal cases. Therefore, it is reasonable to assume that deaths due to this diagnostic category could easily approach the 100% basis.

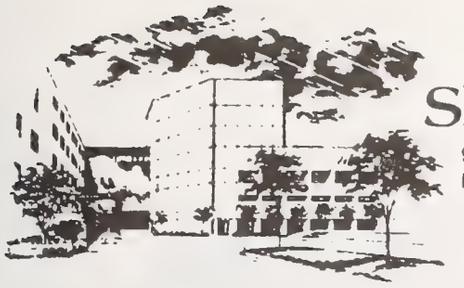
Usually patients entering our facility with a diagnosis of cancer or other related illness have gone through all programs of treatment that could be offered prior to their final admission to our facility. We, therefore do not believe that the mortality rate of 73% as shown on the report is any indication of the less than high quality care that we provide.

Respectfully submitter,

SHELBY MEMORIAL HOSPITAL

W. Garland Strohl,
Chief Executive Officer

WGS:nm



Sherman Hospital
934 Center Street / Elgin, Illinois 60120-9976
Phone: 312/742-9800

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

October 22, 1987

Provider # 140030

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

We appreciate the opportunity to comment on the hospital mortality data prior to its release in December, 1987. Sherman Hospital is a 418-bed, not-for-profit, community hospital. Because of our commitment to quality and patient outcomes we have an ongoing, systematic program whereby peers evaluate the quality and appropriateness of care provided to all patients. This includes an indepth retrospective review and evaluation of all mortality cases. The clinical management as well as the severity of illness and the co-morbidity of the patient are considered by the reviewer. If an opportunity to improve care is identified, appropriate action is taken by the medical staff.

The following paragraphs represent data verification efforts on our part as well as interpretive remarks which we believe should be published along with the HCFA Statistics.

Data Verification

The data released by HCFA indicate that a total of 2,267 Medicare patients were included in the sample. Additionally, that a total of 266 Medicare patients admitted to the hospital died within 30 days of admission. Of these, 219 died while still a patient of the hospital while 47 died after discharge.

Our own records indicate that 3,632 Medicare admissions occurred in 1986. After subtracting multiple admissions of individual beneficiaries, the total sample size is 2,647 compared to HCFA's 2,267. Our records also indicate that 249 patients died while in the hospital rather than the 219 inpatient deaths HCFA reported. We have verified the hospital data, but are unable to verify HCFA's data, particularly as it relates to the deaths after discharge. Also, without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is not possible to verify the accuracy of the information submitted to HCFA.

Relying, therefore, on our own data, the actual mortality rate, all causes, is 11% and not 12% as HCFA published. The actual mortality rate, all causes, excluding deaths outside the hospital is 9%. This seems to be a more equitable statistic as the HCFA data includes deaths which may have no relationship to the hospital stay or treatment.

Interpretive Remarks

While this hospital's actual mortality rate due to all causes, as well as in each of the sixteen subcategories, falls within the range of predicted mortality rates, we have concerns regarding the data in general:

1. No allowance has been made for severity of illness within diagnostic category. That is, a patient may have multiple medical problems with several complicating factors where death is the anticipated outcome.

2. The data contained in the HCFA release is not a measure of quality of care. It is information based on a probability model and not established fact. HCFA used a statistical method for arriving at estimates of "expected mortality" based on certain selected patient characteristics, and then compared these estimates with actual mortality. The model does not consider all factors that influence the risk of death. Significant deviations from the predicted rate could be the result of differences in the type of patients admitted.

3. By measuring mortality within 30 days of a hospital admission, there is no way to fairly assess the quality of hospital care using mortality rates of patients who died from causes which may be unrelated to their hospital stay. Quality judgments can only be made after reviewing the information contained in a patient's medical record.

4. In those subcategories where we approach the higher side of the predicted range, it is important to understand that we provide specialized treatment modalities for the care of these patients. Our ope heart surgery program coronary angioplasty, and end-stage renal disease programs are well known throughout the area we serve. We treat patients who are of a higher risk classification; and, consequently higher mortality rates in these categories are to be expected in our institution as compared to other facilities which do not provide these services.

5. Some hospitals can be expected to experience a lower mortality rate using the HCFA model of deaths within 30 days of admission due to socio-demographic factors. One would expect deaths after discharge to be less in a population where there is a supportive environment at home and in the community. Additionally, where resources are available to provide for continuing care in the home or the nursing home environment, the outcomes should be noticeably improved. These lifestyle issues in various geographical areas may not be apparent to the more casual reader of mortality statistics.

Again, thank you for the opportunity to comment.

Sincerely,

John A. Graham

John A. Graham
President

JAG:jw

Silver Cross

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P. O. Box 26676
Baltimore, MD 21201

Dear Dr. Roper:

Silver Cross Hospital is an acute care facility licensed for 393 beds, and located 40 miles south of Chicago in Joliet, Illinois. A non-profit community hospital, Silver Cross has served Joliet and surrounding communities since 1895.

Among the many patient care services offered by Silver Cross are those which treat severely ill patients, including our kidney dialysis unit, a cancer care center, and hospice.

Our Hoffman Cancer Center treats patients from the entire Will County area and many nearby communities. For 15 years we have offered the only dialysis unit in the area for the many residents suffering from advanced kidney disease. Due to this fact, we see many of the most severe cases for treatment.

In addition, these are relatively long-term conditions where patients have the opportunity to choose their place of treatment. Many people do leave the area initially to go to some of the larger teaching hospitals, which then refer them to Silver Cross as their community hospital to continue their treatments.

We also offer our community a hopsice unit, specifically designed to meet the needs of terminally ill patients and their families. This is a compassionate, caring and supportive service needed in the community, but not one that is good for a hospital's mortality figures.

Quality care is our highest priority at Silver Cross, and many steps are taken to monitor the level of care available at our institution. Mortality figures are a part of our quality assurance system, which includes physician review completed following each patient death.

However, we do stress that mortality data are only a part of our overall quality assurance system. All patient charts are reviewed by quality assurance staff according to a variety of specific criteria, including, but not limited to, mortality.

The data provided by HCFA appears to be accurate when compared to our own figures, and Silver Cross comes within the predicted levels established. Yet we do not consider mortality rates on their own to be an indicator of the quality of our care.

Sincerely,

Keyton H. Nixon
President
Silver Cross Hospital

Irving Rudman, M.D.
Vice President
Medical Affairs

South Chicago Community Hospital
2320 East 93rd Street
Chicago, Illinois 60617
312/978-2000

SCCH

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Medicare Provider #140048

Gentlemen:

Enclosed are comments submitted by South Chicago Community Hospital on the Hospital Mortality Information as compiled by the Health Care Financing Administration of the Department of Health and Human Services. Also attached are the analysis sheets with our identifying comment.

We have thoroughly reviewed the list of 221 cases of deaths submitted to us by the Health Care Financing Administration for their Mortality Study and note the following discrepancies.

In thirteen cases, the date of admission is different between our records and the Study. In eight cases, a difference is noted between either our date of discharge and HCFA's date of discharge or our date of death and HCFA's date of death. There are twenty-eight instances of differences in age between the records of South Chicago Community Hospital and HCFA. There are two instances of the name being spelled differently between our records and HCFA's records. It should be pointed out that because the names are spelled differently, we are not certain that either or both organizations are speaking of the same patient. And, in one instance, we have no record of a patient being either admitted or treated at this institution when HCFA's records show that the patient had been admitted here.

The total number of errors, out of 221 cases, is 49 or a percentage error of 22%, a rather significant error rate considering the seriousness of the data that is being published. Undoubtedly, it can be argued that a Study of this magnitude which is national in scope will produce some errors, but it is precisely because of the 22% error rate that perhaps the Study is too big in scope and thus an error rate of 22% seriously questions the validity of the Study.

Secondly, there are 19 patients who were discharged alive from this institution but who died later on within 30 days of their admission to the hospital. These 19 are not included in the error total of 49. For HCFA to include these patients within the context of the Study leaves the strong implication that the deaths are attributable to the hospital. It is indeterminable whether this is true or false without a method to track these patients after discharge and full investigate the cause and effect relationships.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

SCCH

Finally, to consider mortality rates as an indicator of quality without the publication of additional data with respect to these deaths or for that matter the hospital itself is totally fallacious and illogical.

In closing, the Study as performed by HCFA and submitted to the hospitals is useless data simply because it contains an error rate of 22% in its accuracy. Therefore, until that error rate is significantly reduced or eliminated; the data is useless to consumers, hospitals, researchers and HCFA.

Sincerely,

Harlan H. Newkirk

Harlan H. Newkirk
President

HHN:mb
Attachment

South
Suburban
Hospital

17800 South Kedzie Avenue
Hazel Crest, Illinois 60429

312/799-8000

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We have reviewed the mortality data sent by the Health Care Financing Authority to South Suburban Hospital on September 21. We find the data to be substantially correct with the exception that the following Medicare beneficiaries died while still inpatients at South Suburban:

1) [redacted] Expiration 6/19/86
2) [redacted] Expiration 10/8/86

While the ability of statistical mortality data to detect variations in the quality of care has not been demonstrated, South Suburban Hospital considers the HCFA data a useful input into its quality assessment system. Currently, South Suburban Hospital and its Medical Staff incorporate mortality review into the hospital-wide quality assurance program. Every mortality is reviewed on a case by case basis by a committee of physicians practicing in the appropriate specialty. When the committee identifies an opportunity for improvement in the quality of care, appropriate action is taken and the results are monitored to ensure that care is improved.

We look forward to the refinement of HCFA's model and the success of the Joint Commission's current efforts to produce statistical measurements of the patient care process and patient outcomes. We believe that identifying variations in such measures will prompt additional case review by our quality assessment groups, enabling continuous improvement in treatment options, individual practice and hospital systems.

Sincerely,

Robert Rutkowski
Executive Vice President

RR/kl

St. Anne's Hospital West

ANCILLA SYSTEMS AFFILIATE

365 East North Avenue
Northlake, Illinois 60164
Telephone (312) 345-8100

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

I am writing on behalf of St. Anne's Hospital West regarding the release of HCFA mortality data. The following comments should be included:

There are several general limitations of the data that must be taken into consideration before drawing any conclusions. First, the use of a 30 day post-admission mortality rate will attribute to the hospital deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge or that resulted from the management of the patient at home or in a post-acute care facility. Second, by using the last admission, the sample of cases examined is biased toward those resulting in death which will overestimate the probability of having a hospital stay result in death. Third, although the statistical model using to derive the expected range takes case mix into account, there is no allowance made for severity of illness within the diagnoses or number of patients. (HCFA does acknowledge this limitation.) Fourth, by using the final hospital stay for patients, the sample of cases examined is skewed toward those resulting in death, which should result in both an overestimate of the probability of having a hospital stay result in death and a higher than expected death rate for hospitals that care for larger than expected numbers of terminally ill patients. Fifth, given the statistical model employed the "range of predicted mortality rates" reflect two sources of uncertainty. The first is the relative confidence that can be placed in the prediction, given that the model does not consider all factors that influence the risk of death. The second factor is simply chance; because at best the model can only predict the chances of death, the actual number of patients who die can vary, resulting in differences between the actual and predicted mortality rate even if the model happened to make a correction prediction. Thus, at best the model offers crude estimates of the expected risk of death.

I hope that in the future HCFA will take these considerations into account.

Sincerely,

Bernard Dickens, Jr.

Bernard Dickens, Sr., FACHE
Chief Executive Officer
Chicgo Affiliated Healthcare Group

DRL/ab

St. Anne's Hospital

ANCILLA SYSTEMS AFFILIATE

4950 W Thomas Street
Chicago, Illinois 60651
Telephone (312) 378-7100

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

I am writing on behalf of St. Anne's Hospital regarding the release of HCFA mortality data. The following comments should be included:

There are several general limitations of the data that must be taken into consideration before drawing any conclusions. First, the use of a 30 day post-admission mortality rate will attribute to the hospital deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge or that resulted from the management of the patient at home or in a post-acute care facility. Second, by using the last admission, the sample of cases examined is biased toward those resulting in death which will overestimate the probability of having a hospital stay result in death. Third, although the statistical model using to derive the expected range takes case mix into account, there is no allowance made for severity of illness within the diagnoses or number of patients. (HCFA does acknowledge this limitation.) Fourth, by using the final hospital stay for patients, the sample of cases examined is skewed toward those resulting in death, which should result in both an overestimate of the probability of having a hospital stay result in death and a higher than expected death rate for hospitals that care for larger than expected numbers of terminally ill patients. Fifth, given the statistical model employed the "range of predicted mortality rates" reflect two sources of uncertainty. The first is the relative confidence that can be placed in the prediction, given that the model does not consider all factors that influence the risk of death. The second factor is simply chance; because at best the model can only predict the chances of death, the actual number of patients who die can vary, resulting in differences between the actual and predicted mortality rate even if the model happened to make a correction prediction. Thus, at best the model offers crude estimates of the expected risk of death.

I hope that in the future HCFA will take these considerations into account.

Sincerely,

Bernard Dickens, Sr.

Bernard Dickens, Sr., FACHE
Chief Executive Officer
Chicgo Affiliated Healthcare Group

DRL/ab

Saint
Anthony
Medical
Center

Medicare Provider Number: 14-0233

5666 East State Street / Rockford, IL 61108-2472 / 815/226-2000

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

I appreciate the opportunity to review and comment on the Health Care Financing Administration (HCFA) selected mortality information about Medicare patients treated in short-term acute care hospitals in 1986. We are pleased to note that Saint Anthony Medical Center falls within the range of predicted mortality rates as reported by HCFA. This is consistent with the fact that Saint Anthony Medical Center has a commitment to delivering only the highest quality of care to our patients.

We do, however, have trepidation in publishing rates and tables of this kind since they are subject to misinterpretation by the public even if complete validity was used in the compilation. Concern, therefore, comes relative to this data's interpretation as well as its validity. As you are aware, some hospitals are referral centers and draw complex cases from surrounding geographic areas. This is true for Saint Anthony Medical Center, particularly because we are designated as the Regional Trauma Center and also offer services through our Regional Heart Institute. These cases may represent patients with immediate life-threatening conditions, long-standing heart disease in acute distress, and complex cases which are not usually treatable in facilities with fewer technical resources. Therefore, the severity of illness factor is higher. Yet this factor has not been taken into account for the purposes of this mortality data. Other factors that are omitted are patients who are transferred in from nursing homes, presence of a terminal illness and patients refusing aggressive treatment.

Following the review of our hospital-specific data, it has been found that at least one case, by HCFA's own definition, did not fall into the low-risk heart disease category. One case alone drops the actual mortality rate by one point.

In addition, we question the definition of low-risk heart disease and how this classification is determined relative to the compilation of these data. Although HCFA states that factors such as selected comorbidities are taken into account, there are patients in our low-risk heart disease category that have history of heart bypass procedures and other sigificant multisystem disease.

Again, we are pleased to note that Saint Anthony Medical Center falls within the range of predicted mortality rates.

Sincerely,

K D. Schoeplein

Kevin D. Schoeplein
Administrator

KDS-DF/slt/wpc

SAINT ANTHONY'S HOSPITAL

[illegible] ANTHONY'S WAY ALTON, ILLINOIS [illegible] PHONE (618) 465-[illegible]

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Madam or Sir:

Attached are the comments we prepared regarding Saint Anthony's Hospital Mortality Data and our concerns regarding the entire approach taken.

For purposes of identification, our Medicare provider number is 14-0052.

After reviewing the list of individuals whose last admission was to our hospital and who died within thirty days of that admission, we found five instances where our records did not compare to yours. This list is also attached with the discrepancies highlighted in yellow.

It was helpful to be able to review this data and offer our comments before you released it to the public.

Sincerely,

William E. Kessler
Executive Director

-7

Enclosures

"TO SERVE GOD IS TO SERVE HIS PEOPLE"

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

SAINT ANTHONY'S HOSPITAL

SAINT ANTHONY'S WAY / ALTON, ILLINOIS 62002-0340 / PHONE (618) 465-2571

Medicare Provider Number: 14-0052

COMMENTS ON THE HCFA MORTALITY DATA

The data used by HCFA indicates that a total of 174 Medicare patients admitted to Saint Anthony's Hospital in 1986 died within thirty (30) days of admission. Of these, 134 died while still a patient of the Hospital, while forty died after discharge. Our own records indicate that 1,780 Medicare admissions occurred in 1986 while HCFA data indicate there were 1,182 Medicare admissions. This difference is due to multiple admissions of individual beneficiaries.

Of the sixteen diagnostic categories listed, Saint Anthony's Hospital had 0 that fell outside the range of predicted, mortality rates. After correcting for errors in the data, Saint Anthony's Hospital still did not have any diagnostic categories whose actual mortality rate was outside the range of predicted mortality rates.

Results of our Medicare Record Review showed several errors in the HCFA data used to conduct the analysis. These errors included: 1) a person listed who was never a patient at Saint Anthony's Hospital, 2) an incorrect diagnosis, and, 3) inclusion of two 1987 hospital deaths in the 1986 analysis.

Although Saint Anthony's Hospital fell within the range of predicted mortality rates, we want to mention the major limitations the model has while pointing out unique services that Saint Anthony's offers.

1. Only the last admission of a Medicare beneficiary is used in HCFA's analysis. Previous admissions, regardless of the hospital, are excluded. Therefore, the number of deaths at Saint Anthony's Hospital were compared to a smaller number of admissions (33% smaller) than what actually occurred. This caused our actual mortality rates to be higher than they should be.

2. It should be emphasized that the HCFA data deal only with Medicare patients, who are naturally older than the general population. In fact, the average age of the patients used in the data was seventy-nine years. Therefore, these figures do not address Saint Anthony's overall "success" rate with a specific diagnosis.

3. Although 1986 data were used, deaths were identified through January 31, 1987. Thus it appears a patient dying in January would be counted twice, both in 1986 and 1987.

4. Patients who died after being transferred from other hospitals to Saint Anthony's Hospital were counted as deaths at Saint Anthony's Hospital regardless of the quality of treatment or length of stay at the other hospital.

5. Because the HCFA list includes all patients who died within thirty days of admission, it is possible that deaths that were unrelated to the condition of the patient at the time of discharge were attributed to Saint Anthony's Hospital i.e. weather-related accidents, car accidents, holiday related stresses, etc. When reviewing records of the deaths that occurred after discharge, it was found that there were eight patients whose cause of death was not related to the diagnosis of their last admission.

6. Hospitals who treat only a few patients in a diagnostic category could have their mortality rates misinterpreted. The smaller the number of cases, the more likely this will occur, (i.e. in seven of the sixteen diagnostic categories shown, Saint Anthony's Hospital had twenty-five or fewer cases).

7. The data does not distinguish the source of the patient's admission. Those patients admitted from nursing homes or through our Emergency Room are generally more high risk compared to other patients.

8. Saint Anthony's Hospital operates programs that attract the elderly and terminally ill patients (i.e. Hospice, Home Health, Extended Care Facility). Of the total number of patients who died at Saint Anthony's Hospital in 1986, fifteen were in our Hospice Program. Since one requirement of a Hospice program is that the patient be terminally ill, we feel these patients should not be included in the analysis.

We want to emphasize that the HCFA data are not, in themselves, measures of hospital quality. Given the above limitations, the data should not be used to judge the quality of care provided by different hospitals.

Saint Anthony's Hospital currently has its own quality indicators in place that measure the outcome of care. We feel our quality assurance plans provide a better measure of hospital performance.

We would urge HCFA to reconsider its approach given the unique nature of the indices that they used to develop this method. Unless healthcare institutions have an identical patient mix, which is unlikely given the five criteria that are used to establish the predicted mortality ranges, patient outcomes cannot be compared. Unfortunately, we are concerned the mass media might try to do such comparisons.

St Anthony's Memorial Hospital

503 North Maple Street
Effingham, Illinois 62401
217-342-2121

Medicare Provider Number: 140032

COMMENTS ON 1986 HCFA MORTALITY DATA

A review of the HCFA data for St. Anthony's Memorial Hospital shows all actual mortality rates to be within the HCFA "Range of Predicted Mortality Rates." It is also noted that 29 of the reported deaths actually occurred after discharge from the Hospital. Since Hospital records do not account for events after discharge, it is difficult to tell if these deaths were related to the Hospital stay. If these 29 patients were not included in the data, the overall Hospital Medicare mortality rate drops from 14% to 12% and the deaths by diagnostic category drop by as much as 6% in three categories.

We did verify the mortality data provided by HCFA and found variations in age and date of discharge on nine patients. Only 1,369 of the 2,326 Medicare admissions to our Hospital in 1986 were included in the HCFA study, since each patient was counted once regardless of the number of admissions they had. However, all Medicare patient deaths were included. A more valid statistical approach would be to compare all deaths to total number of admissions, which results in a lower mortality rate.

Although we respect the public's need to have information on the quality of health care in order to assist in decisions about their care, we are concerned that the information they receive is accurate and meaningful. Unverified statistics could be misleading and could unnecessarily alarm patients about their health care facility. These statistics are most beneficial to Hospitals to identify areas where additional review is warranted. Physician peer review is a mandatory portion of the quality assurance process. Only after this review can it be determined whether a quality problem exists or whether the high or low results are explained by other factors.

St. Anthony's Memorial Hospital, including its Board and Medical Staff, has a strong commitment to quality and has an effective hospital-wide quality assurance program in place. One portion of this program is the mortality review, which includes screening of all deaths. Any areas with potential or perceived problems are reviewed in more depth so steps can be taken to resolve problems if warranted and to continuously improve care. The HCFA mortality data will be used in the quality assurance process to identify areas where special study may be of benefit and to compare to Hospital data.

Our primary concern with the current HCFA mortality rate methodology is that it does not include measures of severity; for example, how ill the patient was when admitted, whether they had a terminal illness, whether they were transferred from a Nursing Home, or what their general psychological or health status was. Since all hospitals differ in the types of services they offer and the communities and patients they serve, a severity of illness factor is an important component in understanding and predicting mortality rates.

Other perceived problems with the HCFA mortality rate methodology are: including deaths within 30 days of admission regardless of whether they died in the Hospital or after discharge; focusing on the principal diagnosis or reason for admission rather than the cause of death; using a model that has yet to be verified to see if it accurately predicts expected mortality rates and identifies areas of quality concerns.

St. Anthony's Memorial Hospital appreciates consumers' and hospitals' need for comparative quality of care and mortality data. The American Hospital Association (AMA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are also investigating methods of evaluating hospital quality that rely on measures other than mortality rates. We look forward to working with HCFA, AHA and JCAHO on refining methodologies to evaluate and compare quality of health care.

Gregory A. Voss
Executive Vice President

St Anthony's Memorial Hospital

503 North Maple Street
Effingham, Illinois 62401
217-342-2121

MEDICARE PROVIDER NUMBER: 140032

ERRORS NOTED IN MORTALITY DATA WITH CORRECTIONS

Patient ID Number (HIC)	Surname (1st 6 Ltrs)	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Principal Diagnosis
[redacted]		CE	~~063~~ 065	F	10-30-86	11-02-86	11-02-86	4349
[redacted]		CE	~~072~~ 071	F	06-14-86	06-29-86	06-29-86	4349
[redacted]		HM	~~078~~ 080	F	07-18-86	07-19-86	07-19-86	4280
[redacted]		HM	~~068~~ 069	M	05-19-86	05-20-86	05-20-86	4281
[redacted]		HS	~~092~~ 091	F	11-24-86	11-28-86	11-28-86	4109
[redacted]		HS	071	M	~~07/21/86~~ 07-20-86	07-21-86	07-21-86	4101
[redacted]		PN	082	M	01-19-86	01-24-86	~~01/25/86~~ 01-24-86	486
[redacted]		PN	083	F	09-10-86	09-10-86	09-10-86	~~482.1~~ 428.1
[redacted]		SE	~~090~~ 091	F	11-18-86	12-04-86	12-04-86	03849
[redacted]		UN	~~081~~ 080	M	08-21-86	09-04-86	09-04-86	438

ST. ELIZABETH'S HOSPITAL

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

I am writing on behalf of St. Elizabeth's Hospital regarding the release of HCFA mortality data. The following comments should be included:

There are several general limitations of the data that must be taken into consideration before drawing any conclusions. First, the use of a 30 day post-admission mortality rate will attribute to the hospital deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge or that resulted from the management of the patient at home or in a post-acute care facility. Second, by using the last admission, the sample of cases examined is biased toward those resulting in death which will overestimate the probability of having a hospital stay result in death. Third, although the statistical model using to derive the expected range takes case mix into account, there is no allowance made for severity of illness within the diagnoses or number of patients. (HCFA does acknowledge this limitation.) Fourth, by using the final hospital stay for patients, the sample of cases examined is skewed toward those resulting in death, which should result in both an overestimate of the probability of having a hospital stay result in death and a higher than expected death rate for hospitals that care for larger than expected numbers of terminally ill patients. Fifth, given the statistical model employed the "range of predicted mortality rates" reflect two sources of uncertainty. The first is the relative confidence that can be placed in the prediction, given that the model does not consider all factors that influence the risk of death. The second factor is simply chance; because at best the model can only predict the chances of death, the actual number of patients who die can vary, resulting in differences between the actual and predicted mortality rate even if the model happened to make a correction prediction. Thus, at best the model offers crude estimates of the expected risk of death.

1431 N Claremont Avenue
Chicago, Illinois 60622
(312) 278-2000
ANCILLA SYSTEMS AFFILIATE

1887-1987
NO SERVICE TOO SMALL

I hope that in the future HCFA will take these considerations into account.

Sincerely,

Bernard Dickens, Sr.

Bernard Dickens, Sr., FACHE
Chief Executive Officer
Chicgo Affiliated Healthcare Group

DRL/ab



ST. ELIZABETH HOSPITAL

A Division of the Franciscan Sisters Health Care Corporation

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Caution should be exercised in drawing conclusions from the released statistical data. First, at St. Elizabeth Hospital in Danville, Illinois, the death rate is affected by the hospital being the Area Trauma Center. This results in severely injured patients coming to the hospital. Second, the hospital's Hospice Program, caring for cancer victims, likewise will impact the mortality rate adversely. Third, the methodology utilized in calculating the deaths includes non-hospital deaths. By including all deaths within thirty days following a hospital admission, the statistics are upwardly skewed. A fully recovered patient who suffers an accidental death within thirty days after admission is counted as one of the hospital's mortality. This, we believe, consists of flawed methodology.

Lastly, the lower socio-economic level residents of the Danville area affects the mortality rates. It is generally recognized individuals in lower socio-economic strata are affected more often and more severely by medical problems. Factors such as smoking, exercise, and weight are more prevalent.

Sincerely,

Robert Kelsey
Executive Vice President

REK/dc

600 Sager Avenue • Danville, Illinois 61832 • 217-442-6300

St. Elizabeth's Hospital
211 South Third Street Belleville, Illinois 62222 618-234-2120

October 21, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Washington, D.C. 20201

RE: Comments on Mortality Rate Data

Dear Doctor Roper:

Following are the comments that the Administration of St. Elizabeth's Hospital in Belleville, Illinois have to make in regard to the mortality data to be released to the general public by HCFA.

The only diagnostic category in which the actual mortality rate exceeded the range of predicted mortality rates published by HCFA was that of renal disease. There were 22 patients admitted to our hospital during the calendar year of 1986 and 13 of those patients were listed by HCFA as having died as a result of the renal disease. This was listed as an actual mortality rate of 59% with a range of predicted mortality rates of 14 to 57%. We have analyzed those 13 cases.

To point out that the methodology used by HCFA is misleading, one of these patients who died was admitted to the hospital from a nursing home because of renal failure and was successfully treated. The patient was discharged to the nursing home only to die a few days later of a stroke which was totally unrelated to the renal failure for which the patient was last treated in our hospital. This points out the statistical folly of assuming that an individual who dies within 30 days of hospitalization dies as a result of the problem for which he or she was hospitalized.

HCFA points out that only the last hospitalization of a patient was used in determining diagnostic category for the purposes of the mortality report. Another one of the 13 patients who died was admitted to our hospital on two different occasions during 1986 and the first of those two

hospitalizations was for renal disease, however, at the time of the second and final admission the problem was congestive heart failure for which the patient was treated unsuccessfully resulting in the patient's death. Renal disease did not play a role in that last admission and was not even listed as one of the many secondary diagnoses by the attending physician. That patient, according to the criteria stated by HCFA, should not have been included in the list of 13 deaths attributable to renal disease.

To point out the fact that the mortality data does not take into account the severity of illness, 2 of the 13 patients were referred from another hospital due to severe renal disease, in extremis, both of whom died shortly after admission to our institution. These 2 cases again were charged against our statistical data and were the result of severity of illness not capable of being treated at an institution of a lesser level. For comparison, the Illinois Hospital Association published data on a 6 month period which included the last quarter of 1985 and the first quarter of 1986 which showed that, in St. Elizabeth's Hospital, there were 19 cases of renal disease with a mortality rate of Medicare patients of 26.32%, well below that data published by HCFA in regard to the calendar year of 1986. That same study also showed our hospital as treating 17 non Medicare patients with renal disease and the mortality rate in that population was 0%. This would indicate that Medicare patients are more likely to die of their disease than the non Medicare patients and would also attest to the greater severity of illness in this age group.

Over estimation of death rates will also occur simply because the elimination of prior hospital stays for the patients who died will reduce the death rate denominator without changing the numerator. Several of the patients who eventually were included in the 13 deaths had one or more prior admissions to St. Elizabeth's Hospital during the calendar year 1986 and these admissions were not taken into account when calculating the mortality rates. It does point up to the increased severity and frequency of illness in the Medicare age group.

In summary, it would be apparent that the mortality data presented by HCFA in regard to the treatment of renal disease at St. Elizabeth's Hospital is skewed and misleading as attested to by analysis of the cases involved.

Sincerely,

Harold S. Harsin, M.D., A.B.F.P.
Medical Director

HSH/pb
c: Gerald Harman, EVP

SAINT
ELIZABETH
MEDICAL
CENTER

2100 Madison Ave.
Granite City, Ill. 62040
(618)798-3000

October 27, 1987

Department of Health & Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Gentlemen:

We have reviewed the mortality rate information which is planned to be published by HCFA. Our statistical data shows us to be within the normal range for all categories. However, we still elect to comment because we believe this information is a poor indicator of measuring quality of care.

1. We are in agreement with the Illinois Hospital Association in that HCFA has made some fundamental methodological errors in the model used for their data release. First, the use of a 30 day post-admission mortality rate will attribute to the hospital deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge. Second, using the last admission, the sample of cases examined is biased toward those resulting in death which will increase the probability of having a hospital stay result in death.

2. Some patients do not die from the principle diagnosis. For example, a patient hospitalized for pneumonia who died from cancer within 30 days of discharge is counted as a pneumonia death. Elderly patients commonly have several life-threatening problems at the same time.

3. The data does not show the source of the patients. Those admitted through the emergency department are generally high-risk candidates compared to other patients. Patients admitted from nursing homes tend to be more critically ill than those admitted from their own homes.

4. The data may also be misleading if there are only a small number of cases in a particular group. The smaller the number, the more likely the number is subject to misinterpretation. Moreover, while the published information applies only to Medicare patients, the public may think the data applies to all patients.

An Equal Opportunity Employer

Dedicated to the Good
Health Care of the Community

Area Wide Trauma Center

5. Taken alone, the data does not allow for an interpretation concerning why a patient died or whether the death could have been avoided. Only an examination of the patient's medical record could identify the particular circumstances.

6. The figures deal only with Medicare patients, who are naturally older than the general population, and does not address a hospital's overall "success" rate with a specific diagnosis.

7. The usefulness of the mortality rates in general is questioned as an indicator of the quality of care since there tends to be a great variance in a hospital's Medicare mortality rate vs. the Non-Medicare rate vs. the hospital's overall average rate.

Certainly before disseminating this report, the data should be collected for a number of years. Only if the observations remain somewhat constant for each hospital from year to year can it be considered reliable even though questions of validity would still remain.

Sincerely,

ST. ELIZABETH MEDICAL CENTER

Ted Eilerman
President

TE/cm

saint francis hospital 355 ridge avenue evanston, illinois 60202 312/492-2350

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland

Re: HCFA Mortality Data

Dear Sirs:

Saint Francis Hospital of Evanston shares in HCFA's concern that health care users be better informed in order to make intelligent decisions regarding their care.

The HCFA studies on mortality provide one element which can contribute to these decisions. The isolated release of mortality data, however, leads to the possibility that users will equate these figures alone with the determination of quality. This inference might be valid if all surveyed hospitals offered the same services and cared for patients with the same severity of care.

Although Saint Francis Hospital ranks in the low to mid range in all but one category, we would like to comment on our ranking in the sepsis category. Of the 75 cases cited, we were attributed with 37 deaths or a 51% mortality rate. Of the 37 who died, 24 were 75 years of age or older; 16 had a length of stay of 8 days or more; 11 died within the first three days of admission with 7 dying within one day. In addition, all cases had from 2 to 17 secondary diagnoses (including 19 cardiac arrests) any of which could have been the actual cause of death although the admitting diagnosis was sepsis. These figures indicate that the patients we have seen were severely ill.

Saint Francis Hospital treats a large number of very sick older people because it also operates the Saint Francis Extended Care Center, the North Shore Visiting Nurses' Association, and a Mobile Home Care Unit. Patients cared for by these programs are admitted to the hospital only after they have become too severely ill for the home or nursing home facilities.

These comments are made to address the severity of illness of patients listed in one category, and, to point out that the quality of care received by these patients is not reflected in the raw data released. Patients trying to draw conclusions from such raw data could easily be mislead.

Sincerely,

Sister M. Alfreda, O.S.F.
President and CEO

SMA:dl

ST. FRANCIS HOSPITAL
& HEALTH CENTER
12935 South Gregory Street
Blue Island, Illinois 60406
312·597·2000

October 26, 1987

Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Sir:

The data used by HCFA indicate that of the 3,088 Medicare patients admitted to St. Francis Hospital & Health Center, 384 died within 30 days of admission. Of these deaths, 317 died while still a patient of the hospital, while 67 died after discharge.

Our own records indicate that 5,799 Medicare admissions occurred in 1986. Presumably the discrepancy refelcts multiple admissions of individual beneficiaries to the hospital or different hospitals.

We have no way of verifying whether the number of Medicare patients treated at St. Francis Hospital & Health Center is correct. Our own records indicate that of the 379 Medicare patients who were coded as dead at the time of discharge, the remaining 5,420 admissions were still alive at the time of discharge.

It is impossible to determine the percentage of the Medicare patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Sincerely,

ST. FRANCIS HOSPITAL & HEALTH CENTER

S. H. Gumbiner, M.D.
Medical Director

SHG:jkm
cc: Bryant R. Hanson
Kathy Wisneski
Cyndee Hartz

Medicare Provider
Number - 14-0118

ST. FRANCES XAVIER CABRINI HOSPITAL
COLUMBUS • CUNEO • CABRINI MEDICAL CENTER

811 South Lytle Street • Chicago, Illinois 60607 • 312/883-4300

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
200 Independence Avenue, Southwest
Washington, D.C. 20201

Dear Dr. Roper:

The information provided to us regarding our 1986 Medicare Mortality Rates has been reviewed by the appropriate administrative and medical staff members of our institution. The accuracy of the data for the patients that expired while hospitalized was verified and found to be in agreement with our records.

Although our hospital's actual mortality rate was found to be within the range of predicted mortality rates for our institution, it was felt that several other factors should be taken into consideration:

1. The average age of the patients included in the data should be stated. For our institution, the average age was 80 years. This data should be regarded in comparison with what the average life expectancy is calculated to be for a given year.

2. Strong consideration should be given to the co-morbidities that the patients had. Many of the patients included in our data were residents of nursing homes due to their multiple medical problems and overall debilitated health conditions.

3. The data disseminated to the general public should be in the same format as it was distributed to the hospital for review. If only percentages are used, the data could be easily misinterpreted as in the case involving small numbers, 2 out of 4 would be a 50% rate.

In conclusion, we feel that looking at the mortality rates restricted only to the Medicare population would not be a valid indicator to judge to quality of care rendered by an institution. It would be appropriate to use data which included all age groups.

Our institution is committed to providing quality of care to all patients, and to this end, we have our own hospital-wide and medical staff quality assurance monitoring activities. Review of our mortalities is done routinely as part of our medical staff quality assurance activities.

Sincerely,

Lawrence A. Biro Ed.D.

e

Lawrence A. Biro, Ed.D.
Chief Operating Officer

ST JAMES HOSPITAL MEDICAL CENTER
Specialized Medicine With A Human Touch

October 20, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

This letter is in response to your September 21, 1987 letter regarding the Health Care Financing Administration's (HCFA) plans to publish selected mortality information about short term care hospitals and your request that hospitals review the information about Medicare experience in their individual hospitals and provide comments.

Please be advised that while St. James Hospital Medical Center falls well within the published range of predicted mortality rates in all sixteen diagnostic categories, we would like to take this opportunity to object to the collection and release of this data. HCFA's release of mortality data has been criticized by every major health organization as being inaccurate, unfair to hospitals, and misleading to the public. We concur with this criticism. The proposed statistics cannot be considered an accurate measure of quality care. Among other things, the data does not take into account severity of illness or patient case mix. Furthermore, the statistics are difficult, if not impossible, to validate as they take into account statistical information not readily available to hospitals, specifically patients who die up to 30 days after discharge.

We acknowledge HCFA's attempt to improve on the validity of the data by adjusting for sex, age, and other variances. However, even with these improvements, the statistics are still severely flawed and of little value to the public. We hope that you will take these concerns into consideration before making any future releases.

Sincerely,

Sister Antoinette Marie

Sister Antoinette Marie
President

SAM/pw

St. John's Hospital
800 East Carpenter
Springfield, Illinois 62769
217/544-6464

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Service
Health Care Financing Administration
Washington, DC 20201

Medicare Provider No. 14-0053

Dear Doctor Roper:

Upon reviewing the mortality data provided by HCFA, we find our hospital lies well within the predicted range. However, we wish to express the following concerns regarding HCFA's current use of this data:

1. Quality is measured through a number of coexisting interrelated variables--not just one. Until HCFA can factor in a severity of illness adjustment, the mortality data as presented is inappropriate for publication to the public. Those hospitals serving as regional trauma centers or cancer centers with hospices specifically attract those patients who are closest to death. These, as well as other intervening factors, are not reflected in the data.
2. HCFA data includes all patients who died within 30 days after their last admission to the acute care inpatient hospital. The data does not acknowledge transfers of patients to non-PPS hospitals (where they might have died) nor does it discriminate between the patient who died while in the hospital and the patient who died after leaving the hospital's surveillance.

We understand HCFA is aware of the many limitations of this data and encourage the administration to enunciate these deficiencies when the data is publicized.

Sincerely,

Allison Laabs
Administrator

Saint Joseph Hospital

77 North Airlite Street
Elgin, IL 60123-4912
Telephone 312 695-3200

A Division of the
Franciscan Sisters
Health Care Corporation

COMMENTS ON THE HCFA MORTALITY DATA
SAINT JOSEPH HOSPITAL, Elgin, Illinois
Medicare Provider Number 140217

Data Verification

The data released by the Health Care Finance Administration (HCFA) indicates that 1,465 Medicare patients were admitted to St. Joseph Hospital during 1986 (calendar year) with a diagnosis falling into one of the 16 categories of illness selected for this study. Of these patients admitted, 223 patients died within 30 days of admission. According to HCFA, 181 patients died while still hospitalized, and 42 died after they were discharged. Our own records indicate that there were 2,373 Medicare admissions in 1986. Presumably, the discrepancy is due to the same individual being admitted more than once during the year. HCFA has counted only the last admission, our data includes all admissions.

In conclusion, we have verified the Hospital data, but are unable to verify HCFA's data, particularly as it relates to the deaths after discharge from the Hospital.

Interpretive Remarks

A preliminary review of the data released by HCFA indicates that St. Joseph Hospital deviates from the predicted mortality rates for only one of the 16 diagnostic categories. The actual mortality rate for pulmonary disease as specified in the HCFA release is 36 percent. It is our view that the severity of illness for patients in the disease categories of cancer (123 cases) and pulmonary disease (130 cases) adversely affects the mortality rate.

The initial review of the pulmonary medicine cases was performed by Patient Review Managers, specially trained nurses, employing criteria which classified cases according to severity of illness. That is, describing how sick a patient is based on physical condition and medical services required. This analysis showed that 12 patients were afflicted with a malignancy and other chronic medical conditions. Following this review, a member of the medical staff with a specialty in pulmonary medicine was selected to review the 45 death charts. Employing criteria which assessed the status of the patient upon admission, this physician made a determination for each patient's prognosis. His review indicated that all but one of the patients had co-morbid conditions and complications which rendered their prognosis to range from poor to grave with death as the expected outcome.

Finally, it is important to note that the services provided by St. Joseph Hospital may result in mortality rates which are higher than HCFA's prediction model for certain diagnostic categories. Specifically, St. Joseph Hospital serves as a cancer referral center for the Fox Valley area. The Regional Cancer Center of St. Joseph Hospital offers various modalities of treatment for patients afflicted with cancer. Accordingly, St. Joseph Hospital provides programs specializing in the treatment of

Interpretive Remarks (continued)

patients with an increased severity of illness, often in terminal stages likely to result in above average mortality rates.

This Hospital believes that it is imperative to comment on the limitations of the HCFA approach. HCFA's statistical method is predicated upon an expected mortality which identifies deaths within 30 days of admission to the Hospital. The additional 30 day period presumably can attribute deaths after discharge which are entirely unrelated to the condition of the patient while under treatment during the hospital stay. Sound epidemiological studies are contingent upon formula which expresses the denominator as total patients treated during the year. Thus, the HCFA model does not result in a true inpatient mortality rate, but rather magnifies the death rate.

In addition, the use of only the patient's last hospital admission biases the results toward the death cases. The mortality rate is expressed as a fraction: the number of deaths (numerator) divided by the total number of cases (denominator); HCFA's model elimninates all stays prior to the last admission, causing the denominator to be smaller, thereby overestimating the overall death rate. Thus, hospitals that treat large numbers of patients whose condition is severe (such as cancer) would appear to have a higher than expected mortality rate.

The final comment involves the use of the HCFA data for drawing conclusions on the quality of care rendered at an individual hospital. HCFA, itself, concedes the limitations of employing such data as a basis for assessing the quality of care rendered by different institutions. As already implied, the severity of illness is an important element in the final outcome of care. Hospitals caring for patients with dissimilar characteristics will obviously have different mortality rates. Determination of the quality of care rendered at a hospital can only be made after a detailed review of the information in the patient's medical record.

ST. JOSEPH'S
HOSPITAL MEDICAL
CENTER

2200 East Washington
Bloomington, IL 61701
309-662-3311

October 15, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: Proposed Release of 1986 Mortality Rates
Provider 14-0162
St. Joseph's Hospital, Bloomington, Illinois

Dear Sir:

I am in receipt of Medicare's proposed release of 1986 mortality rates for our hospital.

I am pleased to see that even using Medicare's standards, St. Joseph's Hospital is either below the predicted mortality rate range or within the range considered normal for each and every diagnostic category.

However, even with this positive finding I feel compelled to state the inadequacies of the Medicare model used to determine these type of findings for each and every hospital across the nation.

First, Medicare arrived at its determinations based on a probability model. Probability models, by definition, are accurate only when samples are large enough to represent the population being sampled. Stated another way, the proportion of patients who would be accurately predicted to expire at any given hospital could only be done if that hospital had exactly the same patient characteristics as the national average with respect to each patients' diagnosis, age, sex, complications, and other indicators of medical/clinical condition. As a result, each hospital's sample size is so small, that whether its true mortality rate is accurately represented is open to question. Minimally, a higher number of cases should be established before a mortality rate is computed. This may entail utilizing data from multiple years.

The statistical model is also flawed in that it measures the relationship between a limited number of patient characteristics and the risk of death. Medicare has attempted to design a statistical model that predicts the risk of dying for different types of patients. At best, the model offers crude estimates of the expected risk of death. The model fails to consider a wide range of factors which have a significant impact on patient mortality.

Examples include, but are not limited to, the patient's general health status, the stage of the patient's illness, the patient's psychological condition, and patient wishes with respect to extraordinary life saving efforts, for example, "do not resuscitate" orders. The "right way" of measuring these factors is still a source of dispute but, can be plainly stated as not being taken into account in this model.

Another way in which the model is flawed is that it does not compensate as to whether a hospital offers an "average" or representative set of patient services. This clearly changes among small rural hospitals vs. larger teaching hospitals. At St. Joseph's we are extensively involved in providing care for the terminally or acutely ill, and also serve as a regional referral center for acutely ill patients. Examples include that we offer the only Cancer treatment program in McLean County, we have the only cardiac cath lab in McLean County, and we serve as the regional trauma center.

Medicare's model is flawed in yet another manner. The mortality rates attributed to each hospital includes deaths that occurred within thirty days of a hospital admission. The model therefore attributes some deaths to the hospital stay when in fact the death had no relationship to the hospital stay or treatment. Prior patients who died as much as thirty days after a hospital admission for unrelated causes such as automobile accidents, murder, and other health problems are attributed as a hospital related death. There is no way to fairly assess quality of hospital care using mortality rates in this manner. If we would exclude these unrelated deaths from the database, St. Joseph's mortality rate would reduce from an already acceptable 14% to a 10.6%. This rate is near the bottom end of the mortality rate range established by Medicare. Yet another related flaw in this model is that Medicare counted only the number of patients treated in 1986, not the number of times a given patient was admitted to the hospital. Since many Medicare patients are readmitted to a hospital several times within the same year, using only number of patients instead of number of admissions by each patient to the hospital has the effect of inflating the mortality rate. Medicare data in this model showed that we had 850 cases at St. Joseph's. In affect, we had nearly 1,400 Medicare admissions in 1986. This would further reduce our mortality rate to 6.5% which is far below even the low end of the predicted Medicare mortality rate range.

Finally, the Medicare data are not, in themselves, measures of hospital performance. Under no circumstances should they be used as the basis for judging the quality of care provided by different hospitals. Attributing a patient death to hospital performance using this model is no more equitable than it is to state that an automobile manufacturer is at fault for all accidents without taking into consideration the safety habits of the driver, weather conditions of the road, or likelihood of an accident happening at sites of high incidence.

I am concerned that rather than informing and educating the health care consumer, mortality data released will serve only to confuse the public by giving the impression that mortality statistics can be used to measure quality. This provides a disservice to everyone, hospitals and the public alike.

I appreciate the opportunity to comment on this proposed data release and hope the suggestions of the health care community will not be ignored by Medicare when planning future data releases.

Sincerely,

Kenneth J. Natzke
Administrator

KJN:jl

S J
M H

St. Joseph Memorial Hospital

800 North Second Street • P.O. Box 588 • Murphysboro, IL 62966
Phone (618) 684-3156

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Fanancing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for providing us with the opportunity to review and respond to the 1986 HCFA Mortality Report before it is published. Our review of the data reveals several areas of disagreement, which we have indicated in the enclosed formal response. Among these are incorrect percentages (one death among nine patients in the category of Metabolic and Electrolyte Disorders was reported by HCFA as 22% rather than the correct 11%), as well as contested diagnosis classification and inaccurate Medicare admission data.

We are concerned that all inaccuracies identified will be corrected in order that the public not be misinformed, and we therefore hope that our corrections will be included in toto in the published report.

Despite assurances to the contrary, it is our feeling that public response will be unfavorable regarding quality of care at any given institution. In order to make the "informed decisions" you refer to in your September 21 letter, consumers need to understand the limitations of the HCFA data base, as well as the many other issues to be evaluated in assessing quality patient care. We hope that, in publishing this report, HCFA will make reference to some of the other criteria the public needs to consider.

Sincerely yours,

John D. Groves, FACHE

John D. Groves
President and CEO

BG/das

Enclosures

S J
M H

St. Joseph Memorial Hospital

800 North Second Street • P.O. Box 588 • Murphysboro, IL 62966
Phone (618) 684-3156

COMMENTS ON THE HCFA MORTALITY DATA
October 22, 1987

DATA VERIFICATION

The data used by HCFA in developing the 1986 Mortality Report differs from information kept by St. Joseph Memorial Hospital covering the same time. HCFA indicates there were 623 Medicare admissions, whereas hospital records reveal 1096 Medicare admissions. HCFA indicates 75 deaths within 30 days of admission, whereas hospital records reveal 64 deaths. It is difficult to determine the number of patients dying after discharge, as information concerning death after discharge in not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the data used in the analysis.

INTERPRETIVE REMARKS

In the diagnostic category of sepsis, the hospital's actual mortality rate falls outside of the range of the Predicted Mortality Rate. After correcting the errors in the recording of deaths, there are no categories in which the range is outside the Predicted Mortality Rate (see attachment). Overall statistical differences were also noted, as included in the attachment. Several factors may account for the difference.

HCFA reported eight deaths attributed to sepsis, whereas hospital data reveals five or six, depending on classification of data. One of the eight patients was admitted from another hospital and another was admitted within 30 days of discharge from another hospital. This represents 25% of the patients in the sepsis category. Are these patients included in the mortality data from the other two hospitals?

Additional analysis of the eight sepsis deaths reported by HCFA reveals the following:

- -The cause of death of 38% of these patients is listed in hospital records as "unknown" or a condition other than sepsis.
- -The prognosis at the time of admission of 63% of these patients was such that they were not expected to live.
- -88% had multiple complicating conditions.

-63% were coded 038.9, unspecified sepsis, which is not on HCFA's "Diagnostic Categories" used in the mortality analysis.
-75% were admitted to the hospital from nursing homes or other hospitals.

RESULTS OF MEDICARE RECORD REVIEW

As part of the ongoing quality assurance activities within the hospital, the Medical Staff reviews the records of all patients who die in the hospital. This peer review mechanism requires the Medical Staff to evaluate the quality and appropriateness of care rendered within the hospital. In addition to evaluating patient outcomes, the Medical Staff strives to improve patient care and resolve any identified problems.

The Medical Staff reviewed each of the eight cases reported by HCFA as sepsis deaths, and did not identify any quality issues.

St. Joseph Memorial Hospital

800 North Second Street • P.O. Box 588 • Murphysboro, IL 62966
Phone (618) 684-3156

Medicare Provider Number 14-0140

Diagnostic Category	HCFA Cases	140140 Cases	HFCA Deaths	140140 Deaths	HCFA Actual Mortality Rates	Corrected HCFA Mortality Rate	140140 Mortality Rate (If different)	HCFA Range of Predicted Mortality Rates
All Causes	623	1096	75	64	13%	12%	6%	9-17%
CA	43		13		33%	30%		17-46%
CE	22		8		36%			15-53%
GC	12		0		0%			3-47%
GI	102		3		4%	3%		2-12%
GU	34		2		9%	6%		1-22%
GY	6		0		0%			0-100%
HL	60		4		8%	7%		2-16%
HM	37		7		19%			11-39%
HS	23		7		30%			19-57%
ME	9		1		22%	11%		3-54%
OP	13		0		0%			0-43%
PN	76		15		20%			10-29%
RN	6		1		17%			6-71%
SE	9		8	5 or 6	89%		56-67%	16-74%
TR	14		0		0%			1-39%

Member of the
Health System

2900 N. Lake Shore Drive · Chicago, Illinois 60657

Saint Joseph Hospital
& Health Care Center

October 22, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Medicare Provider #140224

Dear Sir or Madam:

The Administration from Saint Joseph Hospital and Health Care Center has reviewed the mortality data as provided to us by HCFA for the 1986 calendar year. The data received from HCFA indicates that of the 2,424 Medicare patients whose last admission for the 1986 calendar year was at Saint Joseph Hospital, a total of 250 of those Medicare patients died within 30 days of admission. HCFA records show that of these 250 patients, 209 expired in the hospital while the remaining 41 expired within the 30 day time frame post discharge.

Review of our own records indicate that a total of 4,004 Medicare admissions occurred in the 1986 calendar year. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Upon verifying the data received with our records, it is noted that 1 case of the 41 patients listed as expiring after discharge from Saint Joseph Hospital was discharged alive from the hospital after the indicated date of death. This case is corrected in the attached listing. All other cases as noted to have expired in our hospital appear to be correct. It is noted that we have no easy accessible method to verify the expiration of those 41 patients that HCFA has noted as expiring 30 days post discharge from our hospital.

Upon review of the Saint Joseph Hospital's overall mortality rate as compared to the predicted mortality rate range, in all cases, Saint Joseph Hospital's actual mortality rate is within or below the range of predicted mortality rates. Overall, for all causes, the hospital's mortality rate is at the low end of the range. In 6 of the 16 specific diagnostic categories our rate is below or at the low end of the range while in 8 diagnostic categories, our rate is between the low end and the midpoint of the range. In the remaining 2 categories we are above the midpoint of the range, but below the high end of the range. In summary, the overall mortality rate for Medicare patients who expire within 30 days of their last hospital admission which was at Saint Joseph Hospital is 10% which is at the low end of the range of predicted mortality rates for our hospital.

It is noted that HCFA has indicated that the provided hospital mortality data is not a complete measure of the quality of care rendered at an individual hospital, but that the mortality data is a useful tool for measurement. This is a perspective held by HCFA alone.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Mortality data such as that provided by HCFA may be unfairly considered by the public as a measurement of the hospital's performance when in fact it is not a true representation of the quality of care rendered by an individual hospital. Internally the data could be used as a basis to focus the hospital's quality assurance activities.

In summary, until HCFA develops a validated statistical model which can take into account the factors of high risk services provided by hospitals, severity of illness and extreme age ranges of the Medicare patients, etc. to present this data, the public should refrain from using this data as a valid measure of the quality of care rendered by an individual hospital.

Sincerely,

Michael D. Connelly

Michael D. Connelly
President and Chief Executive Officer

MDC/mlp
Enc.

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	45	10	45	9
CE -- Cerebrovascular Accidents	10	4	10	4
GC -- Gastrointestinal Catastrophes	9	1	9	1
GI -- Gastrointestinal Disease	9	1	9	1
GU -- Urologic Disease	1	1	1	1
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	14	0	14	0
HM -- Severe Chronic Heart Disease	15	2	15	2
HS -- Severe Acute Heart Disease	26	1	26	1
ME -- Metabolic/Electrolyte Disturbances	6	1	6	1
OP -- Orthopedic Disorders	1	0	1	0
PN -- Pulmonary Disease	29	8	29	8
RN -- Renal Disease	3	0	3	0
SE -- Sepsis	16	3	16	3
TR -- Severe Trauma	2	0	2	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	23	9	23	8
Total -- All Categories	209	41	209	40

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

st. joseph's hospital
915 EAST FIFTH STREET • ALTON, ILLINOIS 62002 618/463-5151

Medicare Provider #140023

October 21, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Re: Hospital Mortality Information

The mortality information about Medicare patients treated at St. Joseph's Hospital in 1986 has been received and reviewed by the hospital's Quality Assurance personnel. We appreciate the opportunity to comment prior to the December publication.

The hospital specific information has been verified, and it is noted that the mortality rate is within the predicated range for all diagnostic categories.

While mortality rates alone should not guide a consumer's choice in health care, death case review is one aspect of any hospital's Quality Assurance Program. Each case is reviewed by physicians to determine if the care was appropriate, and problems can be handled as they occur.

Even though no problems were identified for St. Joseph's Hospital, we share other hospitals' concerns with the use of this type of information which may give an inaccruate view of the quality of services and do not measure hospital performance.

Sincerely,

Peter H. Alexander
Vice President of Ancillary Services

PHA/cm

HOSPITAL St. Joseph's
Commitment to Caring
1005 Julien Street Belvidere, Illinois 61008 815/544-3411

October 26, 1987

Mr. Thomas G. Morford
Health Care Financing Administration
Department of Health & Human Services
HSQ-148-GNC
P.O. Box 26676
Baltimore, MD 21201

Dear Mr. Morford:

On behalf of St. Joseph's Hospital's Governing Board of trustees and the Medical Staff, thank you for giving me the opportunity to comment on the notice in Federal Register of August 17, describing the intent for the public release of hospital mortality information

Unfortunately this method for determining mortality rates is inadequate and doesn't reflect the quality of medical care patients receive. As you know, this is the second time HCFA will release Medicare mortality information to measure the quality of care. This is done by identifying those patients who died within thirty (30) days of their hospital admission.

I am alarmed that consumers will use mortality data as a standard criteria to measure health care quality.

The reasons that cause the HCFA hospital mortality to be inaccurate are:

1. You need to take severity of illness of each patient into consideration. These statistics include all patient days even those unrelated to the hospital. i.e., traffic accidents or other accidents are included.

2. This report does not follow the hospital's physician peer review process.

3. The present sample/model patient mix is statistically biased. Consequently, the results of the model are biased as well.

4. There is not a large enough sample number of cases to compute reliable mortality rates. Probably models are accurate only when samples are large enough to represent the same population.

5. Additionally, the mortality data is based upon a probability model with only confidence level of 95%.

6. It does not consider patients who died within 29 days after admission.

7. Hospital's patient mix vary by degrees of aging population with greater complications.

8. Hospital's level of technoloty vary for higher risk patients. i.e. Open heart surgery.

An American Healthcare Management Hospital
IL 224

9. Some hospitals have designated high risk intensive centers for emergency traumas, neonatal and pediatrics.

10. The death rates do not indicate why the patient died.

Thank you for the opportunity to comment on this proposed HCGA data release. Hopefully this information will not confuse the public.

Sincerely,

Daniel Cobbs
Administrator/CEO

DC/ae

cc: Governing Board
Medical Staff

C/19/25

St Joseph's Hospital

1515 Main Street
Highland, IL 62249
618-654-7421

COMMENTS ON THE HCFA MORTALITY DATA

October 25, 1987

Medicare Provider # - 140168

After review of the 1986 HCFA mortality data for St. Joseph's Hospital, the death statistics are noted to be within the range of HCFA predicted mortality rates. However, we are voicing our objections to public release of this data, identified as an indicator of quality of care in hospitals throughout the country.

Our objections to the use of the data in the manner proposed by HCFA are:

1. The methodology used is incomplete, inaccurate, and untested; and
2. Mortality rates derived from this limited statistical analysis are not direct measures of quality and can be easily misinterpreted.

These conclusions are based on specific facts. First, the methodology used is faulty. HCFA admits to error in the statistical model used to get expected mortality rates; the model can only predict the chance of death while the actual number of deaths can vary. Actual mortality rates can be higher or lower than predicted because the patients treated by the hospital differ from the patients treated in the "average hospital" or simply because of chance.

Another limitation of the data relates to the selection process for these statistics. Only the last admission of a Medicare patient was included. Thus, if a patient had several admissions, only the last one occurring in 1986 was included in the overall statistics. In our hospital, 952 Medicare admissions occurred; the HCFA data lists 577 admissions. This translates to approximately one-third of our Medicare cases deleted from the statistics.

Another data selection factor is inclusion of patient deaths occurring within 30 days of admission. This means that some of the deaths included in the statistics occurred after discharge from the hospital. HCFA made no effort to determine whether or not the death was related to care provided in the hospital or to other factors beyone the control of the hospital and attending physician.

Another questionable selection factor is that the data is based on the principal diagnosis (reason for admission) rather than the cause of death. This could lead to erroneous classification, causing one diagnostic category to be higher or lower than it actually is. For instance, a patient with terminal cancer could be admitted to the hospital with a principal diagnosis of gastrointestinal distress. If the patient death occurred while in the hospital, the HCFA data would indicate a death in the

Sponsored by
Hospital Sisters
of the Third Order
of St. Francis

gastrointestinal category when actually the patient death was directly related to the terminal cancer.

Our second objection, that the HCFA mortality data is not a direct measure of quality of care, is based on the fact that several significant areas were not included in the HCFA data base. No consideration was given to the following: the patient's general health status, the stage or severity of the patient's illness, the patient's psychological condition, family support, or the patient's request for supportive care without extraordinary measures being taken. All of these areas can be contributing factors to the cause of death and are beyond the control of the hospital or attending physician. The HCFA equation of death=poor quality is in itself erroneous. In many instances, the highest quality of care may be provided and death is still the end result.

The only reliable methodology accepted by most hospitals and health care regulatory agencies to consider mortality data as a quality indicator is to perform a thorough, individual review of each death case. This review includes consideration of all contributing factors related to the death. The data from this indepth review can then be collated into a meaningful statistical analysis.

At St. Joseph's Hospital, indepth review of all death cases has been a part of the overall Quality Assurance Program for many years. The review of death cases is only one of many areas reviewed in our Quality Assurance Program. Our goal is to continually assess and improve the care we are providing.

In summary, the publication of the HCFA mortality data as a quality indicator is a gross misinterpretation of the facts and should be accepted for what it is - another meaningless statistical report.

SAINT JOSEPH MEDICAL CENTER

333 North Madison Street
Joliet, Illinois 60435
(815) 725-7133

Edward J. Schlicksup, Jr.
President

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Enclosed please find the comments of Saint Joseph Medical Center with regard to HCFA's Mortality Report.

I. Data Verification

The data used by HCFA indicate that a total of 414* Medicare patients admitted to Saint Joseph Medical Center died within 30 days of admission. Of these, 357 died while still a patient of the hospital, while 57 died after discharge. Our own records indicate that 5,678 Medicare admissions occurred in 1986 of which 438 expired. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals.

*HCFA had 415, but 1 patient was not on our files.

II. Saint Joseph Medical Center continues to serve as a regional referral hospital in the following categories: Cancer Care, Cardiovascular Disease, Neurological/Neurosurgical Disease, Orthopedic, Pulmonary Disease, and many other medical and surgical specialities.

We are pleased that our efforts are effective in terms of predictable mortality rates and our placement within the acceptable range of HCFA's predicted mortality rates in all categories.

III. The following are the corrections to the data you submitted:

Diagnostic Category	Identification Number	Patient Name	Correction
CA	[redacted]		Date of death should be 10/28/86; HCFA has 10/31/86
HS	[redacted]		Date of death should be 3/12/86; HCFA has 3/31/86
PN	[redacted]		Date of death should be 5/3/86; HCFA has 5/9/86.
PN	[redacted]		No such patient on record
TR	[redacted]		Date of death should be 1/2/86; HCFA has 1/6/86
ME	[redacted]		Procedure Code not listed 48.35; this procedure code appears on the UB-82.

Sincerely,

Edward J. Schlicksup, Jr.
President

Sisters of Mary
of the Presentation

St. Margaret's Hospital

600 East First Street Spring Valley, Illinois 61362 815-664-5311
815-223-5346

October 15, 1987

Department of Health & Human Services
ATTN: William R. Roper, M.D.
Washington, D.C. 20201

Dear Administrator:

This letter is written in response to your selected mortality information report dated 9/21/87.

In reviewing your statistical date for our hospital, #140143, several questions arise concerning this data.

1). Our hospital records for 1986 show a total of 1,374 Medicare admissions and a total of 85 Medicare deaths, with a mortality rate of 6.1%, verses your statistical of 811 cases and a 12% mortality rate. Also, our total hospital admissions for that time period was 4,453 and total deaths were 100. This gives our hospital an overall mortality rate of 2.2%.

2). Twenty two (22) of the deaths you listed were patients who died in another facility or Nursing Home, of which we have no record or knowledge of the care or treatment or the cause of death. Several of these cases are known by their physicians as being non-contributory to the previous hospital 30 day admission diagnosis. One patient listed [redacted] was admitted to our hospital for several hours, to facilitate a transfer to a V.A. Hospital, where he died 28 days later, and was never treated at our institution. We feel these types of patients should be noted as separate statistics, or with the facility were they died.

3). It should also be noted that our hospital has an acute care Cancer Unit, the only one within a 75 mile radius, and we therefore have a greater number of cancer patients who die here, giving us a higher number of high risk terminally ill patients.

It is for these specified and other reasons that we feel this mortality rate information is not only incorrect, but also misleading, and in no way reflects the quality of care of an institution.

We are attaching a copy of the Illinois Hospital Association comparative mortality report for our hospital, which is more in line with our hospital statistics. Each study has different comparative totals, but the total overall data should certainly be closer to our actual hospital records, than your study shows.

Thank you for your consideration in this matter, and we await your response.

Louis P. Lukancic, M.D.
President of Medical Staff
St. Margaret's Hospital

Jerry A. Popowski
President
St. Margaret's Hospital

cg

Attachment

ILLINOIS HOSPITAL ASSOCIATION
COMPDATA

COMPARATIVE MORTALITY DATA

ST MARGARET'S HOSPITAL
SPRING VALLEY

DIAGNOSIS	MEDICARE NUMBER	MEDICARE RATE(%)	NON-MEDICARE NUMBER	NON-MEDICARE RATE(%)	ALL PATIENTS NUMBER	ALL PATIENTS RATE(%)
CANCER	59	11.86	28	25.00	87	16.09
STROKE	22	4.55	1	0.00	23	4.35
SEVERE ACUTE HEART DISEASE	1	0.00	*	*	1	0.00
SEVERE CHRONIC HEART DISEASE	2	0.00	1	0.00	3	0.00
GASTROINTESTINAL CATASTROPHES	21	9.52	3	0.00	24	8.33
METABOLIC & ELECTROLYTE DISORDERS	4	0.00	*	*	4	0.00
PULMONARY DISEASE	58	8.62	122	0.00	180	2.78
RENAL DISEASE	14	14.29	6	0.00	20	10.00
SEPSIS	1	0.00	3	0.00	4	0.00
SEVERE TRAUMA	*	*	4	0.00	4	0.00
OPHTHALMOLOGIC DISEASE	4	0.00	8	0.00	12	0.00
GYNECOLOGIC DISEASE	7	0.00	36	0.00	43	0.00
LOW RISK HEART DISEASE	60	1.67	28	0.00	88	1.14
GASTROINTESTINAL DISEASE	64	3.13	177	0.00	241	0.83
UROLOGIC DISEASE	35	0.00	13	0.00	48	0.00
ORTHOPEDIC CONDITIONS	42	2.38	88	0.00	130	0.77
ALL OTHER DIAGNOSES	293	4.44	967	0.10	1260	1.11

IL 228.2

ST. MARY HOSPITAL

MEMBER OF FRANCISCAN SISTERS OF THE POOR HEALTH SYSTEM, INC.

October 27, 1987

Harvey Brook
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Brook,

The anticipated release of mortality statistics by HCFA to the public has caused us concern and we appreciate the opportunity to pass those concerns on to you.

Of greatest importance, we feel, is that the data do not consider the cause of death in assigning cases to one of the 17 categories. Patients who die in traffic accidents, for example, will bias the statistics in that category of disease for which they had been previously treated.

The sample size also causes concern. How valid are the statistics, for example, in categories of 3 patients?

Another major concern is that this data is being presented as a measurement of the quality of care. A valid measure of quality would be to look at cases, determine if death was inevitable and, if not, determine if management was appropriate. This is done through a peer review process and truly addresses quality whereas statistics only serve as indicators or screens. Consumers will be misled by mortality statistics released as, to quote Dr. Roper, "a giant step" toward improving the quality of care provided to Medicare beneficiaries.

Again, thank you for the opportunity to comment.

Cordially,

James Strieby, President/CEO

JS/cmd

Saint Mary of Nazareth Hospital Center

2233 West Division Street, Chicago, Illinois 60622 (312) 770-2000

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Finance Administration
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Roper:

Please include the following comments with the report of mortality information regarding Saint Mary of Nazareth Hospital Center, Chicago.

1. Our review of the cases listed in your report indicate limitations in its accuracy. There were errors in the report for 13% of the cases. These were errors in patient name, diagnoses, date of discharge, date of death, principal diagnoses and principal procedure.

2. The report fails to address issues related to the severity of illness prior to death. As a teaching hospital, complicated cardiovascular and cancer patients are referred to Saint Mary of Nazareth Hospital after being treated in other settings. An important indicator of the severity of their illness was that 88% were in our intensive care unit at some time during their hospital stay. This severity was further evidenced by the observation that twenty percent died within three days of admission, in spite of these highly sophisticated intensive care services.

   Similarly, as an inner city hospital which coordinates regional Emergency Medical Services, Saint Mary of Nazareth Hospital Center receives critically ill patients through its emergency room. Fifty six percent of the patients who died entered our hospital through the Emergency Room. Also of significance, twenty five percent of these deaths were patients who were unknown to the physician on our staff prior to their admission.

Sponsored by
The Congregation of the Sisters of the Holy Family of Nazareth

3. We concur with your position that the mortality information provided in your report is not recommended "to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals"

The errors in documentation described above as well as the failure of the report to reflect issues of case severity or demographic bias can mislead any thoughtful reader if used as the only basis for judging the quality of care. At Saint Mary of Nazareth Hospital Center, medical records of all patients who die (not just Medicare patients) are reviewed by trained quality review professionals and physicians. This review uses pre-determined criteria to assess the quality of care provided. The results of these audits, irrespective of the findings, are reported to the medical and hospital staff to insure a high standard of care.

Sincerely,

Sister Stella Louise

Sister Stella Louise, C.S.F.N.
President

SSL:mr

ST. MARY'S HOSPITAL
400 North Pleasant • Centralia, IL 62801 • 618-532-6731

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P O Box 26684
Baltimore, Maryland 21207

Medicare Provider # - 14-0034

Dear Doctor Roper:

St. Mary's Hospital has noted several discrepancies and concerns when comparing HCFA data to hospital specific data:

The total number of cases listed by HCFA versus the total number of hospital Medicare discharges for the year 1986 varies approximately 44%.

Over 12% of the deaths were recorded by including patients who died outside the hospital.

The mortality rate for deaths that did occur in the hospital were computed on a smaller number of cases because patients that were transferred to another institution were not counted in the number of cases reported.

Inappropriate diagnostic category classification was caused by using the principal diagnosis not necessarily related to the cause of death and by not including all significant ICD-9CM codes into the diagnostic categories.

Thank you for reviewing and including our comments.

Sincerely,

Sr. M. Clarette

Sister M. Clarette, CSSF
President/CEO

SMC/nt

St. Mary's Hospital
Medicare Provider #14-0155

St. Mary's Hospital

HCFA MORTALITY DATA RELEASE

After an extensive review and evaluation of the information contained in the HCFA Mortality Data Release, St. Mary's Hospital is submitting the following comments in an attempt to: (1) provide verification of the HCFA data; (2) explain the meaning of the HCFA data; and, (3) offer a response.

I. VERIFICATION OF DATA

HCFA Data		Actual Data	
Inpatient deaths	- 181	Inpatient Deaths	- 186
Post-hospital deaths	- 31	Post-hospital deaths	- 26
	212		212

Of 212 identified Medicare beneficiary deaths, HCFA reports 181 deaths occurring during an inpatient admission, with an additional 31 attributed to a 30-day post-hospitalization period. In fact, upon review of this data, 186 of the reported deaths occurred during hospitalization, with 26 deaths attributed to the post-hospitalization period.

All but one of the 26 deaths occurring in the 30-day post-hospitalization period were considered terminal cases due to chronic illnesses, with 9 patients being discharged to home care and 17 transferred to skilled care/nursing homes.

HCFA Reported Data	
Mortality Rate	12%
Predicted range	9 - 16%
Reported Cases	1,757

	Cases	Deaths
High Risk Conditions	689	165
Low Risk Conditions	576	36
All Other Conditions	492	11
	1,757	212

II. RESPONSE TO DATA

St. Mary's Hospital recognizes that the public is entitled to meaningful data concerning the quality of hospital care. However, simple death rates are not a true measure of quality of care, as a certain number of deaths are to be expected in any hospital, depending on the age, condition and types of patients cared for.

The Board of Directors of St. Mary's Hospital establishes, maintains and supports, through the Chief Executive Officer and the President of the Medical Staff, an ongoing Quality Assurance Program. Ongoing medical staff peer review assessment of every patient admitted is conducted through the Quality Assurance process. This quality of care review includes not only Medicare beneficiaries, but all patients. All deaths are extensively reviewed. The information in turn is evaluated and follow up is conducted by the Quality Assurance Committee of the Board of Directors.

0759R

St. Mary's Hospital of East St. Louis, Inc.
129 NORTH EIGHTH STREET, EAST ST. LOUIS, ILLINOIS 62201

PHILIP J. KARST, PhD
Executive Director
(618) 482-7025

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I have received the mortality data for St. Mary's Hospital which you are planning to publish in December, and I wish to provide the following comments.

As I am sure you know, data, even when "adjusted," requires thorough understanding and some analysis by the reader before worthwhile and accurate conclusions can be drawn. The presentation of this mortality data therefore is not likely to provide any worthwhile information to the general public, but instead may very likely be misleading and potentially very damaging to specific institutions.

The extent to which the more serious patients already select their hospital carefully and the fact that you include all deaths occurring within 30 days of discharge causes me to doubt the reliability of your data as an indicator to use in evaluating a hospital.

Health care will never be so simple that a single set of numbers

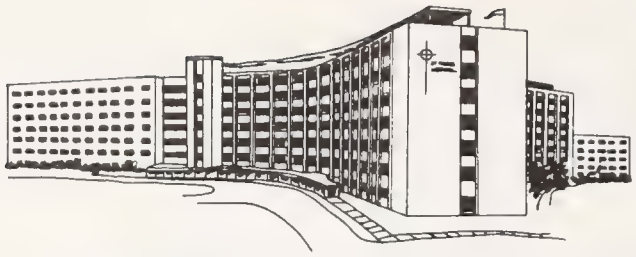
can properly describe the quality of an institution. It is so upsetting when those individuals, like yourself, who have such tremendous influence on the future direction of the health care industry, seem so ready to accept such a simple approach to dealing with such a complex issue.

Thank you for allowing me to comment.

Very truly yours,

Philip J. Karst, Ph.D.
Executive Director

ap



ST. MARY'S HOSPITAL

On The Lake • 1800 East Lake Shore Drive • Decatur, Illinois 62525-3883 • Telephone (217) 429-2966

October 12, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Washington, D.C. 20201

RE: Medicare Provider #140166

Dear Doctor Roper:

This letter is written in response to your letter to us dated September 21, 1987 presenting mortality information about Medicare patients treated in our hospital in 1986.

Enclosed please find corrected copies of patient specific data.

Should you have any questions with regard to this matter, please do not hesitate to contact me.

Sincerely,

Terence J. Schuessler
Executive Vice President

TJS:jac

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

saint therese medical center
2615 Washington Street • Waukegan, Illinois 60085 • (312) 249-3900

October 27, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Doctor Roper:

I wish to take this opportunity to comment on the mortality statistics for Saint Therese Medical Center, Waukegan, Illinois.

A review of our mortality statistics indicates that in one category, our mortality rate is above the range of predicted mortality rates. This category is for the diagnosis of cancer. We believe that the higher than predicted mortality rate may be attributed to the fact that Saint Therese Medical Center operates the oldest Hospice in Lake County Illinois. Additionally, our Hospice program was the only inpatient Hospice in Lake County functioning during the statistical reporting period. Many of these Hospice patients seek no treatment for their disease process, but do seek alleviation of symptoms, and an environment in which support is offered as the patient faces the prospect of dying. The average age of Saint Therese Medical Center patients who succumbed to cancer during the reporting year was 74 years.

Another category of disease entity in which our mortality rate ranged toward the high end of the predicted range of mortality rates was pulmonary disease. Saint Therese Medical Center is the only hospital in northern Lake County with a Respiratory Care Unit. Additionally, the staff physician who serves as Medical Director for our unit was the only pulmonary specialist in northern Lake County during calendar 1986. For this reason, and because the average age of our Medicare patients who succumbed to pulmonary disease was 82 years during the reporting period, we believe that there is a rationale to the higher than median mortality which obviates the need to question the quality of care provided. As a further point, several businesses and industrial complexes in our area employ materials in production which are found to be irritants to the pulmonary and respiratory system, and in some cases, are known to be carcinogenic and able to promote chronic obstructive pulmonary disease.

In two other disease categories our statistics seem to be above a mean level. These categories are cerebral vascular accidents, and gastrointestinal catastrophies. In both cases, we attribute the higher than average mortality rate to average ages for these disease categories which are above what a normal range for patients would be. In the case of cerebral vascular accidents, the average age during the reporting period for patients who succumbed to this category of disease was 78 years, and for gastrointestinal catastrophies, the average age was 77.6 years.

We are gratified for the opportunity to provide our perspective on this information, and we hope that you will take into consideration our comments as you contemplate public disclosure of this information.

We will be happy to further address any points concerning this statistical information, and I encourage you to contact me directly if any follow-up is required.

Sincerely,

Leo F. Garrison
Executive Vice President

LFG:mhy

SwedishAmerican
PEOPLE WHO CARE

Evelyn F. Nichols, R.N., M.S.P.H.
Vice President, Patient Services

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to review the HCFA mortality statistics for SwedishAmerican Hospital. It is our belief that this statistical analysis should be viewed only as a tool to identify potential areas for further review or evaluation. Unfortunately, these data may be interpreted as a direct measure of hospital performance. Publication of mortality statistics could be cause for undue concern by the very public served by the hospital. Realistically, mortality statistics released publicly under the auspices of the Health Care Financing Administration give a distinct impression that the information is meant to be a measure of quality, which is not the case.

As positive as the results appear for SwedishAmerican Hospital (our actual mortality rates for all categories were well within the range of your predicted mortality rates), we remain concerned with the continued use of the HCFA methodology for computing this in the future. The method utilized to predict mortality for each hospital is equivocal. It does not address the severity of the patient's condition, the previous health status of the patient, the psychological and/or psychosocial aspects of the patient's status, nor the availability of post-hospital care. Most importantly, it is impossible to directly relate the actual cause of death to the reason for hospitalization or to the care given in the hospital.

When the data are released in December to the general public, we would encourage prominent indications with the data that (1) the predicted mortality data are based on a probability model and not established fact, and, (2) the data are not a measure of care given by a hospital. The model attributes all deaths within 30 days of admission to the hospital, to that hospital, regardless of whether the patient expired in the hospital, transferred to a nursing home or rehabilitation facility, or returned to his/her own home.

SwedishAmerican Hospital
1400 Charles Street
Rockford, Illinois 61108-1257
815/968-4400 Ext. 4001

The model and statistics attribute a total of 323 deaths to SwedishAmerican Hospital. Of this number, 235 patients expired at SwedishAmerican; there are 88 patients that expired (due to unknown reasons) after discharge. We question the validity of a model that assigns over a fourth of the total deaths to the institution when no direct relationship can be verified.

As stated earlier, SwedishAmerican Hospital statistics fall within the range of the probability model. Regardless of this favorable result, we wish to address certain areas.

We raise issue with the terminology of "all causes" as a diagnostic category. The HCFA explanation of this category is that this encompasses all other principal diagnoses for Medicare beneficiaries besides those already listed (cancer, cerebrovascular accidents, etc.). The use of the term "all causes" infers a correlation between the principal diagnoses and "cause of death", which clearly has not been established.

The percentage of deaths attributed for severe chronic heart disease also indicates the questionable validity of the model for predicted mortality rate. SwedishAmerican Hospital has a wide referral base for cardiac patients. This institution was a forerunner in the United States for procedures such as percutaneous transluminal coronary angioplasty and balloon valvuloplasty. The excellence of the medical and surgical cardiac treatment has resulted in a high volume of referred patients, presumably patients who could not be adequately treated elsewhere. We would have expected to see our mortality rate for this category to be higher than what your analysis indicates.

Another low rate that indicates problems with the HCFA model is the Cancer category. Besides the presence of a Radiation Oncology Unit and a nursing unit (Oncology Unit) dedicated solely to cancer patients, SwedishAmerican has a full-fledged Cancer Program. Even with advances in technology and treatment, we would still have expected to have fallen in the upper third of "predicted mortality" rather than the middle third, which your report indicates.

The only two categories that place our assigned mortality rate in the upper third of "predicted" are Sepsis and Cerebrovascular Accident. Again, given that the number of cases is small (14 cases of Sepsis and 21 cases of Cerebrovascular Accident) and the severity normally associated with these diagnoses, the meaningfulness of the data must be questioned.

In your cover memorandum, you noted that the PRO will be directed to analyze the information you are publishing. This is a more legitimate use of these data, since these organizations will be fully cognizant of the factors involved in the model, and the qualifiers that need to be addressed. In the same vein, SwedishAmerican will scrutinize the data in the course of our ongoing quality assessment. The data are a "reference point" for further study, but, we do not accept this as an assessment of the care at this institution.

Sincerely,

Evelyn Nichols
Vice President, Patient Services

EN/lr

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	48	21	48	21
CE -- Cerebrovascular Accidents	19	2	19	2*
GC -- Gastrointestinal Catastrophes	8	5	8	5
GI -- Gastrointestinal Disease	10	6	10	6
GU -- Urologic Disease	3	3	3	3
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	11	4	11	4
HM -- Severe Chronic Heart Disease	17	6	17	6
HS -- Severe Acute Heart Disease	31	3	31	3
ME -- Metabolic/Electrolyte Disturbances	5	6	5	6
OP -- Orthopedic Disorders	1	1	1	1
PN -- Pulmonary Disease	27	12	27	12
RN -- Renal Disease	3	2	3	2
SE -- Sepsis	13	1	13	1
TR -- Severe Trauma	6	2	6	2
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	33	14	33	14
Total -- All Categories	235	88	235	88

* We found patient ID number 343228696A had been identified by an incorrect surname. Marvin, Margaret is the correct one.

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

Swedish Covenant Hospital
5145 North California Avenue
Chicago, Illinois 60625
(312) 878-8200

PROVIDER NUMBER: 140114

COMMENTS REGARDING THE HCFA MORTALITY DATA

Summary
According to the statistics published by HCFA, the mortality rate for Medicare patients admitted to Swedish Covenant Hospital in 1986 falls within the range of predicted mortality rates for every diagnostic category and for the total number of deaths due to all causes. Not withstanding the foregoing summary, the hospital would like to comment on some data discrepancies and sampling problems and provide a more detailed analysis of the information.

Discrepancies and Data Sample Problems
After recalculating the data provided by HCFA we have found several discrepancies in the published mortality rates. The following changes should be noted:

Diagnostic Category	Deaths	Cases	Corrected Actual Mortality Rate
All Causes	292	2082	14% (not 15%)
CA - Cancer	33	158	21% (not 22%)
CE - Cerebral Vascular Accidents	30	93	32% (not 34%)
HS - Severe Acute Heart Diseases	36	80	45% (not 48%)
ME - Metabolic/Electrolyte Disturbances	7	42	17% (not 19%)
PN - Pulmonary Disease	45	164	27% (not 29%)
HL - Low-Risk Heart Disease	6	154	4% (not 5%)

Additionally, there are problems with the statistical sample itself. First, patients who died within thirty (30) days after they were discharged from the hospital are included in the hospital mortality rates. Inclusion of these patients' deaths is not meaningful since it does not necessarily reflect hospital care nor the reasons for the patients' discharges. For example, some patients who are terminal prefer to die at home or in a hospice. Furthermore, patients who later expire, may have been transferred from the hospital to another institution such as an extended care facility in accordance with the Peer Review Organization, (HCFA) criteria. Finally, patients may have died of causes unrelated to their hospital admission. These deaths should not be reflected as hospital statistics.

The second problem with the sample is that it contains only the last admission of all Medicare patients seen in that year. The elimination of prior hospital stays for patients who died reduces the actual number of Medicare cases that were treated in the hospital, thus skewing the results in an overestimate of the death rates. A cancer patient undergoing chemotherapy who is admitted each month for treatment will be reflected only once in the HCFA data. Thus both these sampling problems artificially inflate the mortality rate and may lead to inaccurate conclusions concerning the hospital.

Analysis

The data presented by HCFA indicates that of a total of 2082 Medicare patients admitted, 255 died as inpatients and 37 died within thirty (30) days after discharge. This data is inaccurate in that two (2) of the inpatients died after discharge. One patient, age 72, was discharged in terminal condition to his home at his family's request. The other patient, age 92, had been discharged back to a residential nursing home on the hospital's premises. Thus the hospital's mortality rate for patients who expired in the hospital is actually 12%.

HCFA also provided patient data by diagnosis and risk category. When broken down by category the mortality rates for 1986 were: high risk - 11% (223:2082); low risk - 1% (28:2082); and, "other" (not a high or low risk diagnosis) - 2% (41:2082). Analysis of the total deaths revealed that the average age of a Medicare patient who died was 81 years. Seventy-six percent (76%) (223:292) of the patients who died were in the high risk category; ten percent (10%) (28:292) were in the low risk category and fourteen percent (14%) (41:292) were in the "other" category.

In conclusion, the analysis confirms that, as predicted, the majority of Medicare patients are discharged alive. Those Medicare patients who expire at Swedish Covenant Hospital or within thirty (30) days of discharge are elderly, high risk or terminal patients.

eab
hcfa-jb2

Swedish Covenant Hospital
5145 North California Avenue
Chicago, Illinois 60625
(312) 878-8200

Provider Number - 140114

Corrected patient data - Patients that were not expired at the time of discharge.

[redacted]	CA	073	F	01/25/86	02/17/86	02/17/86
[redacted]	ME	092	F	06/24/86	07/07/86	07/07/86

THOREK HOSPITAL AND MEDICAL CENTER
Chicago, IL
Hospital ID Number 140115

COMMENTS ON PUBLISHED MORTALITY STATISTICS

Thorek Hospital and Medical Center, in coordination with its medical staff, has implemented and maintained a comprehensive quality assurance program in conformance with applicable Joint Commission on Accreditation of Healthcare Organizations standards for several years. One small but important component of this quality assurance program is mortality review. Because Thorek Hospital has a fairly small number of deaths occurring in the hospital, each medical record of an expired patient (as compared to a sample of patients) is reviewed by a medical staff committee. Information gathered from this review is aggregated so that patterns and/or trends can be identified and evaluated by the clinical service. Should a pattern or trend develop, examples of action that may be taken include coordinated educational efforts, examination and revision of patient management protocols, or monitoring of individual providers.

During 1986, Thorek Hospital and Medical Center provided treatment to 6,176 inpatients. The most common diagnosis seen at Thorek Hospital in 1986 was treatment of cancer patients, either with chemotherapy, radiation therapy, surgery or medical support. Another important point to make is that over 15.5% of Thorek Hospital's inpatient admissions were patients over the age of 65, an age group where multiple health problems are the norm.

The statistics being released by the Health Care Financing Administration cover only Medicare patients who died within thirty days of admission to Thorek Hospital. Please note that this data includes patients who received treatment at Thorek Hospital, but died sometime after their discharge from the hospital. It is unknown to us at Thorek Hospital the cause of these deaths, and in fact, the death could be completely unrelated to the reason for their Thorek hospitalization. In fact, 7 of the 44 deaths listed for Thorek Hospital occurred anywhere from four to fourteen days AFTER the discharge from the hospital.

Because the numbers reviewed for Thorek Hospital are relatively small, and in some cases as few as three cases may be used for statistical analysis, please remember that the data percentages reflected may appear to be significant, when in fact they are skewed because of the small number of cases reviewed. For example, if three cases are included in a sample and one death occurred, the mortality rate published will be 33%. However, if that one death was the only death in an extended sample of like patients over several years, it is obvious that the actual mortality rate over a more significant sample would be much lower. Please look at the number of cases included when reviewing this data and remember that the fewer cases included, the greater the skew of the statistical result may be.

In reviewing the data to be published for Thorek Hospital, the actual mortality rates stated for all diagnostic categories except one fall within the range of predicted mortality rates. Therefore, this discussion will focus only on the diagnostic category of severe acute heart disease (HS). Included in this diagnostic category are such diagnoses as acute myocardial infarction (heart attack), cardiac arrest, ventricular tachycardia and fibrillation, cardiogenic shock, and ruptured aortic aneurysm. As the title of this category suggests, the diseases are of a severe nature and are acute (recently developed).

The data published indicates that Thorek Hospital treated 9 such categorized patients, that 78% of these patients died, and that the expected range of mortality for the hospital should be 14 to 71%. In developing this response, the medical records of each of these expired patients was again reviewed. Record review revealed that each of these patients suffered from several serious medical illnesses in addition to that condition that caused them to be included in this category. For example, one patient who suffered from an acute myocardial infarction (heart attack) also had an acute cerebrovascular accident (stroke), uncontrolled diabetes, and experienced a second heart attack when hospitalized, prior to expiring. Another patient suffered from cardiac arrest and also had gangrene of the foot (underwent an above knee amputation), arteriosclerotic heart disease, respiratory failure, lung abscesses, carcinoma of the prostate and chronic obstructive pulmonary disease. Other conditions found in the other patients in this category include pulmonary edema, premature atrial contractions, pneumonia, renal failure, urinary tract infection, dehydration, dementia, carcinoma of the lung, superior vena cava syndrome and pleural effusion. Each of these conditions, by itself, might warrant hospitalization, and superimposed on an already acute heart disease, could have serious implications for recovery.

In your review of this published data, Thorek Hospital would like to emphasize what this data does and does not show. The model that has been used to release this data considers a few factors that may impact the likelihood of risk of death, but does not consider a wide range of factors with an equally significant potential impact on mortality. For example, factors not considered in this model include the patient's general health status, the severity of the patient's disease processes, the stage of the patient's illness, the patient's psychological condition, and the support (be it family or otherwise) available to the patient.

More seriously, however, is the limitation that this data is only statistical numbers and therefore cannot indicate quality of medical care rendered, especially without consideration of factors such as those detailed in the preceding paragraph. It is unknown whether hospitals with actual mortality rates below the predicted range actually provide higher quality care, or if hospitals with actual mortality rates higher then the predicted range provide lesser quality care. These statistical analyses of mortality rates can do no more than screen cases for further review. They can do no more than provide a basis to ask further questions, they cannot provide answers. Judgments as to quality of care rendered can only be made after a

thorough review of the information contained in the patient's medical record and information garnered from the patient's physician.

Your consideration of the limitations of the model and the other comments offered above when reviewing the information published for Thorek or any other hospital will result in the appropriate emphasis being placed on the information published.

Thorek Hospital and Medical Center is proud of the care and caring shown to all its patients and the quality of treatments offered. Our commitment to the highest, most progressive standards of health care has never been stronger.

Union County Hospital

517 North Main Street

Anna, Illinois 62906

Union County Hospital
517 North Main Street
Anna, Illinois 62920
Provider Number 140170

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore,Maryland 21207

ATT: William L. Roper, M.D.
Administrator

Dear Dr. Roper:

After reviewing HCFA's Hospital Specific Mortality Data, Union County Hospital's Administration has the following comments: The Hospital's Mortality Rates fell within HCFA's predicted range, but we do not consider this data to be an indication of quality. Figures alone can often be misleading. As a 40 bed facility, our case numbers tend to be smaller than other hospitals thereby making our Mortality Rate higher, eg, if two cases are admitted to the hospital and one dies the data would reflect a 50% death rate. HCFA's Data shows 8 cases of severe acute heart disease were admitted to the hospital and two died giving us a 25% death rate. If taken out of context, 25% Mortality rate appears high but actually only two deaths occurred.

Additionally, HCFA's Data did not reflect the extent of illness for each patient and the elderly patient is usually admitted with a multitude of long term chronic conditions. The hospital however, has a committee of physicians who routinely review all deaths on a case by case basis to determine if appropriate care was rendered. This is the only way quality can be determined.

HCFA's Data indicates a total of 54 deaths with an overall Mortality Rate of 13%. Of these deaths, 22 or 41% occurred outside the hospital. Fifteen of the Twenty Two were transferred from Union County Hospital to other Health Care Facilities for additional care. For informational purposes the average age was 82 years old - 91% or 49 patients were older than 75.

Due to the nature of their illness, many were considered to be terminal and not expected to survive; however, at least 30% of the deaths occurring outside the hospital were from causes unrelated to the hospital stay. HCFA's data did not account for those patients who wish to die at home or in a nursing home. Again, HCFA's Mortality Data cannot be used as the basis for determining quality care. For fiscal year 1985-1986, Union County Hospital's actual Mortality Rate was only 1.8%.

Thank you for this opportunity to comment on HCFA's Mortality Data.

Very truly yours,

Eugene A. Helfrich

Eugene A. Helfrich, Administrator
Union County Hospital

THE UNIVERSITY OF CHICAGO HOSPITALS

Ralph W. Muller
President

Room A106 Box 430
5841 South Maryland Avenue
Chicago, Illinois 60637
312 702 6240

October 26, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Room 309 G Humphrey Building
200 Independence Avenue S.E.
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to review and comment on HCFA-compiled mortality information on the University of Chicago Hospitals (UCH). It is our understanding that your agency plans to release this data to the public in the near future.

We wish to make both general and specific comments. Some of our general concerns have been voiced previously by others in the hospital industry, but we feel it important to reiterate them at this time. First, we must question the advisability of holding out to the public a supposed method of determining "quality" hospital care based on mortality rates. Such information, as you have indicated, is best used by hospitals in their quality assurance programs; yet by their release to the public HCFA creates the illusion that the results point to high or low quality care.

UCH has always been committed to providing the highest quality of medical care. However, we know that such care should be measured not solely through statistical comparisons, but also through rigorous peer review. Not only do the mortality data fail to do what the public perceives them to do, but they run the risk of creating confusion and apprehension among those they are intended to inform -- the nation's elderly. While we strongly support consumers having access to information on the quality of care they receive, we continue to question using mortality rates for this purpose.

In addition to the overall problem with the public's use of the data, we are concerned about the reliability of the data. The methodology employed by HCFA in developing the mortality rates does not take into consideration variations in severity of illness within diagnoses and/or patient mix. The University of Chicago Hospitals, like other tertiary care university hospitals, have a patient mix decidedly different from other acute care settings. Because we accept and treat the extremely ill patient, under your current methodology our hospitals and other tertiary care centers could be subjected to inappropriate public concern based on this skewed mortality data.

A specific example of this type of aberration occurs in UCH's mortality rates for low risk heart disease. HCFA reports that our mortality rate in this grouping is slightly above the expected norm. A review of the medical records shows that the cases categorized as "low risk" had special circumstances that in reality made these cases moderate to high risk patients. Of the nineteen cases that were reported in this category, 27% had a history of previous open heart procedures; 33% of these patients were transfers from community hospital emergency rooms; and the majority of these patients — some 67% — had multiple organ disease at the time of admission. Unfortunately, none of this severity information is contained in your report. We find this kind of inaccuracy unfair to tertiary care hospitals like UCH and dangerously misleading to patients.

There is no question in our minds that the provision of quality hospital care can best be assured through ongoing review and indepth evaluation of patient clinical information. UCH's Quality Assurance program concentrates on this kind of assessment and consequently we are able to act quickly to identify and correct any potential problems. Certainly mortality rates are a part of our comprehensive quality review process, but they are only one indicator.

We share your concern that all Medicare beneficiaries receive the best possible hospital care, and we will continue to make every effort to assure that only such care is provided in our hospitals. We look forward to the time when the government with the assistance of the hospital industry and its accrediting organizations will be able to offer the public improved information on evaluating the quality of hospital care.

Thank you for your consideration.

Sincerely,

Ralph W. Muller

THE UNIVERSITY OF ILLINOIS AT CHICAGO

Hospital Management (M/C 693)
University of Illinois Hospital and Clinics
Suite 1400
1740 West Taylor Street
Chicago, Illinois 60612
(312) 996-3900

UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS
COMMENT ON HCFA MORTALITY DATA

In the category of sepsis the three cases listed for the University of Illinois Hospital are too small a sample to be statistically meaningful. In the other fifteen categories UIH was within the calculated ranges of the unvalidated HCFA statistical model. What follows are comments on the goals and process of the HCFA procedure and ends with brief summaries of the medical facts of the three patients which illustrate some of the flaws in the HCFA model.

Several years ago HCFA decided to put hospitals under a payment system which would require hospitals to decrease the amount of services rendered to patients. Consequently some patients were discharged early so Congress directed HCFA to develop a system for assessing the quality of care at hospitals. These mortality rates and ranges are the results of HCFA's system. Over 50,000 different manifestations of illness and 10,000 different diagnostic categories have been compressed into sixteen categories from which death rates have been calculated for each hospital and compared with calculated ranges. Thus if a hospital's rate is low supposedly the care delivered is superior and the opposite if the death rate is high. This assumption is incorrect.

HCFA has never validated their method. Low rates are not an indicator of good care and high rates don't imply bad care. Their method is similar to a drug company putting a new antibiotic on the market without first testing to see if it will cure infections. One reason why low rates don't necessarily indicate high quality is that illness severity can vary widely within the same diagnostic categories. For example, one patient with a heart attack may have an uncomplicated hospital stay while another may develop shock, severe heart beat irregularities, or heart failure, yet HFCA categorizes them as the same. Also if more of the complicated cases were transferred to a specialty hospital, that hospital might have a higher death rate in this category.

Besides the serious defect in validation, the HCFA model has some statistical flaws that further invalidate the results as applied to UIH. One of the sepsis cases was transferred to our hospital from another, nearly dead, and died the next day. Another was so senile that she could not swallow food or get out of bed even when not acutely ill. A family decision was made to not resuscitate should she expire. These two cases should not be included.

As a rule of thumb in statistical methods, in order for results to be valid at least 10 events must be observed. Only two of the 16 diagnostic groups meet this standard working rule of epidemiology. Many other hospitals no doubt have this same problem as well.

As previously stated, in the category of sepsis the three cases listed for the University of Illinois Hospital are too small a sample to be statistically meaningful. A review of each case shows that death was the inevitable outcome in each despite intensive antibiotic treatment because each patient had other serious conditions in addition to severe sepsis (blood poisoning). These included advanced age (90 and 85), kidney failure, severe sugar diabetes, severe anemia, kidney and bladder infections, a heart attack, senility, bleeding disorders, an inability to mobilize defenses against infection, disordered blood chemistries, and delayed admissions to this hospital. Each case is summarized below.

The first patient was 56 years old. She died the day after she was admitted after being transferred from another hospital. She had diabetes which had caused kidney failure -- necessitating chronic dialysis, amputations of both legs and nerve damage. Altogether she had twelve different medical problems, the most dangerous of which was that her body's defenses against her infection were so weak that her temperature was <u>eight</u> degrees below normal instead of being elevated.

The second patient, 90 years old, was admitted with a temperature one degree below normal and with other signs of severe blood poisoning which had gotten into his system from infections on his leg. The visiting nurses had been trying to persuade him to come to the hospital for two weeks but he had refused until he collapsed. After admission he was found to be severely dehydrated and to have suffered a heart attack and five other medical problems in addition. Despite intensive treatment he died four days later.

The third patient was an 86 year old lady who had lived in a nursing home because of Alzheimer's disease and inability to swallow. She was fed through a tube surgically placed in her stomach. While in the nursing home, she developed bed sores which became infected and spread into her blood stream. After hospital admission she was treated with antibiotics and responded. While resting quietly during her hospitalization, she suddenly stopped breathing. Her family had previously agreed that if this occurred that no attempts at resuscitation should be made.

WGT:si

WABASH GENERAL HOSPITAL
WABASH HOSPITAL DISTRICT
1418 COLLEGE DRIVE • MOUNT CARMEL, ILLINOIS 62863
(618) 262-8621

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Washington, D. C.,
20201

Dear Sir:

We have reviewed the mortality datas that were submitted to us for Wabash General Hospital. Our reaction to this information is as follows:

1) Mortality related to pulmonary disease is higher than 36% and the reason for this is that debilitated patients have difficulty in clearing the secretions and in turn they are more likely to develop pneumonias. They are less mobile and they are prone to develop deep vein thrombosis. 50% of the time, one cannot diagnose just on clinical grounds. When these patients expire from significant pulmonary emboli, they are included under the pulmonary category. The in-patient population treated for this disease at WGH has an average of 81 years and 65% of the patients were from a nursing home. In general, these patients do have the above mentioned problems in varying degrees. In comparison to most tertiary care facilities, our facility certainly has a heavier responsibility to provide the care for the nursing home patient and the terminally ill patient.

2) In spite of our patient's comorbidity and debilitating condition, these patient's morbidity was relatively lower in gastrointestinal disorders and cardiovascular conditions. As this facility provides more primary and secondary care, our surgical services mainly revolve around gastro-intestinal problems. The mortality figures indirectly support the fact that our patients receive good medical as well as good surgical care. We do have a good team-work force.

Sincerely,

Narendra Anadkat, M.D.,
Committee Chairman/
Medical Director of Respiratory Therapy

WESTLAKE COMMUNITY HOSPITAL • 1225 Lake Street • Melrose Park, Illinois 60160 • 312/681-3000

October 14,1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

This letter is in response to your offer to consider comments in response to the pending release of mortality statistics in December.

First, let me express appreciation for the opportunity to provide some input into this process.

Like many hospital administrators, I am concerned that the statistics compiled by HCFA will, despite the qualifying statements by your agency, be taken by the media, and therefore the public, as some sort of measurement of the overall quality of a health care institution, which it certainly is not.

As has no doubt been pointed out to you in the past, the methods by which this data has been gathered are flawed by such factors as the fact that the 30-day post-admission mortality rate may well, in some cases, attribute to the hospital deaths that were unrelated to the condition for which the patient was under treatment during the last admission.

In addition, the statistics fail to take into account factors that would reflect on an individual's risk of death such as general health status, the stage of the patient's illness, his or her psychological condition or family support.

In addition, the statistics fail to take into account factors such as whether a hospital has programs specializing in the treatment of patients with terminal conditions. In Westlake's case, we are affiliated with a hospice, which we feel may account for the fact that the statistics on cancer deaths, while listing us within the "predicted" range are on the high side.

Again, thank you for the opportunity to comment on these statistics. Should you have any additional concerns or questions, please feel free to contact me.

Sincerely,

Leonard J. Muller
President

cc: Metropolitan Chicago Healthcare Council
Illinois Hospital Association
Franklin C. Brewster
Dr. Behrooz Eshaghy

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Wood River Township Hospital

Dear Sir:

By way of this letter, we are responding to the mortality data which was published for Wood River Township Hospital on September 21, 1987. There are several issues which must be addressed regarding this information.

1. Wood River Township Hospital has a very high case mix index and as such treats patients which have severe disease states.

2. Wood River Township Hospital has an aggressive Hospice and Oncology program which treats patients in the end stages of terminal illness.

3. It is the opinion of Wood River Township Hospital that care must be taken in publishing such comparative mortality data without indication of severity of illness, differences between hospitals, patient programs provided by hospitals such as Hospice programs and aggressive Oncology units, as well as some information regarding the condition of the patient at time of discharge (i.e. Was death an inevitable occurrence given the disease that the patient had?)

In many of the cases which are used by the Health Care Financing Administration to determine the mortality data for our hospital, it was found that many of the patients had multiple conditions which could categorize them in alternate classifications. As an example, both of the gastrointestfnal catastrophies which were published for Wood River Township Hospital died as a result of cancer. One of the gastrointestinal disease patients died as a result of cancer as did one of the patients which had been categorized by the Health Care Financing Administration as having severe chronic heart disease who died of cancer. Given such multiple conditions in many of these cases, many times it is difficult to identify the cause of admission as being directly correlated with the cause of death. The vast majority of the patients which fell into categories of disease which relate to cancer, upon study, have ultimately died as a result of terminal cancer with the results being inevitable, particularly with the Hospice Program at Wood River Township Hospital.

Edwardsville Road • Wood River, Illinois 62095 • 618/254-3821

It is also important for the general public to understand that Medicare patients do have a different mortality rate than do the non-Medicare population. As an example, recently published data shows that for Illinois there is a significantly lower mortality rate for non-Medicare patients than for Medicare patients. This conclusion is not surprising but is important for the general population in evaluating the published mortality data to be aware of such differences in expected outcomes. In addition, comparative data for Wood River Township Hospital based on a sampling of Medicare and non-Medicare patients prepared by the State Hospital Association shows significantly lower mortality for both Medicare and non-Medicare patients than did the published data prepared by the Health Care Financing Administration.

In summary, it must be pointed out that Wood River Township Hospital has a very high case mix index indicating a very high severity of illness of the patients seeking treatment at Wood River Township Hospital and programs which are for the benefit of the terminally ill result in differentials in the mortality rate for our hospital in the community service which we provide.

Thank you for allowing us this opportunity to respond.

Sincerely,

Jerry Bolandis

Jerry Bolandis
Senior Vice President

ram

TECHNICAL APPENDIX

METHODOLOGY

The Data Base

The basis for the present analyses is the MEDPAR file assembled and updated quarterly by the Bureau of Data Management and Strategy in HCFA. This file is constructed from information on hospitalizations submitted to HCFA by hospitals through fiscal intermediaries and from data obtained from the Social Security Administration describing certain characteristics of the patients including age, sex, race and the date of death. Because each Medicare beneficiary is assigned a unique health insurance claim number (HIC), it is possible to link hospitalizations longitudinally to ascertain prior and readmissions, and the date of death whenever and wherever it occurred.

The process of data management consisted of the following steps:

(1) admissions to acute-care hospitals were selected, as was the array of data needed to characterize the patient and the hospitalization;

(2) the first- and last-occurring hospitalizations, their nature as out- or in-transfers, and the number of admissions prior to the last of a given patient in a given calendar year were identified,

(3) patients were assigned to major diagnostic categories by means of the principal diagnoses, their additional diseases identified on the basis of the secondary diagnoses, of which there were up to four for each hospitalization, and separate files were written for each diagnostic category for the first- and last-occuring hospitalization respectively. Analyses were performed on the separate files. For the purpose of assessing overall mortality rates, results obtained for the individual diagnostic categories were aggregated. As a check on the programming, a summary file of the hospital-level data was also written and analyses of this summary file were compared with the results of aggregation of the files for the diagnostic categories.

In this project, the basis used for the assessment of mortality rates was death within 30 days of admission. However, because readmissions can occur within the interval between admission and 30 days thereafter, to avoid multiple counts of deaths, the last-occurring admission in a calendar year was chosen because it is associated with the highest risk of death. The prior experience of the patient was taken into account by identifying whether the last-occurring admission represents a transfer from another acute care facility and by identifying the overall number of prior hospitalizations in the year.

The composition of the diagnostic categories and of the comorbidities was determined in part empirically and in part on the basis of clinical judgment. The diagnostic categories used in these analyses were chosen to follow medical disciplinary lines and to report principally on high-risk admissions but also on certain low-risk admissions. The empirical testing consisted of the computation of the relative risk of death associated with the category or comoribidity compared to that isn a reference population by using standard statistical techniques (The Cox Proportional Hazards Model). A committee of clinical advisors was assembled to review alternatives and to assist in the design of an appropriate classification scheme. The approach adopted for the present analyses is the result of their deliberations and advice.

A list of the ICD9-CM codes included in each diagnostic category and comorbidity is found on the following pages.

Analytic Techniques

The principal analytical tool was logistic regression. Because the diagnostic categories are mutually exclusive, the analyses to ascertain the influence of patient characteristics (age group, sex, comorbidities, prior admissions and transfer status) were carried out separately for each category. If p is the probability of a given patient dying within 30 days of admission, its dependence on the patient's characteristics x_i (covariates) is specified by the logistic model as

$$\log \frac{p}{1-p} = \Sigma_i b_i^* x_i .$$

Once the coefficients b_i have been computed, it is possible to estimate the predicted probability of dying for that patient, and, by averaging over all the patients whose treatment in a given hospital is being evaluated, the predicted mortality rate for that hospital for the individual diagnostic category as well for all categories taken together.

The second quantity required of the analyses was an estimate of the uncertainty in the mortality rate expressed as a range of predicted rates encompassing a specified proportion (95%) of the probable values. For this it is necessary to compute the variance of the probability of death at a given hospital. This quantity is conventionally taken to consist of the sampling variance and of the variance due to the uncertainty in the estimates of the regression coefficients. The latter, given the very large populations used to estimate the coefficients, is negligible compared to the former, and was confirmed to be so by direct calculation.

	DIAGNOSIS	ICD-9-CM CODES*
High Risk		
CA	Cancer	141-160, 162-172, 174-209
CE	Stroke	430-432, 434, 436
HS	Severe acute heart disease	410, 427.1, 427.4, 427.5, 441.0, 441.1, 441.3, 441.5, 441.9, 785.51
HM	Severe chronic heart disease	398.91, 402.01, 402.11, 402.91, 425, 428, 518.4
GC	Gastrointestinal catastrophes	551, 557, 560.0, 560.2-560.9, 570, 572-572.7, 573.4, 567, 578.0, 578.9
ME	Metabolic and electrolyte disorders	250.01-250.4, 251.0, 251.1, 255.4, 276
PN	Pulmonary disease	415.1, 416.0, 480-483, 485-516, 518-519, except 516.1, and 518.4
RN	Renal disease	580-590 except 580.81 and 590.81
SE	Sepsis	DRG: 416, 417
TR	Severe trauma	806, 808.43, 808.53, 820, 821, 828, 850.2, 850.4, 851.1-851.7, 852, 839.0-839.5, 860-867, 887, 897, 900.0, 901-904, 926, 927.0, 928.0, 929.0, 942.3, 942.4, 942.5, 946.3-946.9, 947.1-947.9, 948.2-948.9, 952, 958.0, 958.1, 958.4, 958.5
Low Risk		
EY	Ophthalmologic disease	360-379
GY	Gynecologic disease	617-629
HL	Low risk heart disease	393-429, except 415.1 and 416.0 and cases in categories HS and HM
GI	Gastrointestinal disease	530-579, except 577.0, 573.1 and 573.2 and cases in category GC
GU	Urologic disease	593-609
OP	Orthopedic conditions	712-739, 810-838, 840-848 (excluding cases in category TR)
UN	All other Conditions	All other ICD 9 CM Codes

*All of the above entries refer to ICD-9-CM codes except for the entries for Sepsis which are expressed in terms of Diagnosis Related Groups (DRGs).

COMORBIDITY	ICD-9-CM CODES
Cancer	141-160.9, 162-172.9, 174-208.9
Chronic liver disease	571-572.8
Chronic renal disease	582-583.9, 585-587
Chronic cardiovascular disease	412-414.9, 426-429.1
Chronic pulmonary disease	491-493.9, 496
Cerebrovascular degeneration/ chronic psychosis	290-290.9, 294-299.9
Hypertensive disease	402-405.99, 412-414.9
Diabetes	250.01, 250.1-250.9

(A comorbidity is taken to be present if its ICD-9-CM code appears on the bill as any one of the up to four addtional diagnoses beyond the principal diagnosis.)

The sampling variance for the computation of the range of predicted mortality rates is approximately estimated by

$$[P * (1-P)]/N$$

where P is the proportion who had died of persons at risk, N, within a specified diagnostic category (or overall).

The (negligible) component of variance of the overall mortality rate, due to the regression coefficients is estimated approximately by

$$\Sigma_i[\Sigma_k\Sigma_{k'}p_{ijk}*(1-p_{ijk})*p_{ijk'}*(1-p_{ijk'})*x_{ijk}*C(b_i)*x_{ijk'}]$$

where the subscripts k and k' refer to individual patients, i to the diagnostic category, and j identifies the hospital. However, given the potential systematic differences among hospitals in the severity of illness of their patients, in the quality of care they receive and other unidentified factors, a further contribution to the variance, the interhospital variance, must be considered. This constant term is estimated by

$$IHV = \Sigma_j(P_j-\bar{P})^2*(N_j/N_t)*(1-1/N_j)$$

where P_j is the predicted mortality rate, N_j the number of cases at risk at hospital j, N_t the total number of cases at risk, and $\bar{P}$ the average mortality rate, in the category under consideration. In computations using standardized residuals, the sampling variance was based on the observed mortality rate. The difficulty engendered by the occurrence of a zero mortality rate in some hospitals was overcome by a Bayesian approximation in which the mortality rate, D/N, was replaced by (D+1)/(N+2), where D is the number of persons who died and N is the number at risk.

The ranges of predicted mortality rates given in this publication encompass 95% of the probable values on a logit scale to ensure that the range neither goes below zero nor above 100%. On the logit scale, the range of predicted values, P, is given by

$$R = \log \frac{P}{1-P} \pm 1.96 \frac{\sqrt{[P*(1-P)/N + IHV]}}{P*(1-P)}$$

Retransformed to the linear scale, the upper end of the range is

$$\exp(R_+)/(1+\exp(R_+))$$

and the lower end of the range is

$$\exp(R_-)/\exp(1+R_-)$$

where R_+ is the value of R taken with the (+) sign and R_- is the value of R taken with the (-) sign.

Two subsidiary analytical approaches were employed both as checks of the programming and the computational algorithms, and as validation tools. One was multiple linear regression in which the unit of observation was the hospital, the dependent variable the proportion of persons at risk who had died, and the independent variables within the specific diagnostic categories the proportions of the persons at risk within given characteristics used in the logistic regression. Thus, a direct comparison of the results of the logistic and the linear models was made in the case of the specific diagnostic categories. However, whereas in the computations based on logistic regression results for overall mortality were simply obtained by aggregation of the specific categories (including "Other"), in multiple linear regression analysis of this quantity, the diagnostic categories were used as covariates, along with the other patient characteristics.

The other alternative approach consisted of indirect standardization of mortality rates. The population at risk in each diagnostic category was subdivided by age-group and sex into cells within which average mortality rates were calculated. These rates were then used to compute predicted mortality rates for the age and sex-mix of each hospital.

In addition to the above, cross-validation and boot-strap analysis were used to explore the properties of the models in selected diagnostic categories. In cross-validation, the entire population at risk is randomly divided into two equal subsets and regression analyses are performed on each subset. Predicted mortality rates for the hospitals are computed both directly within each subset and by use of the patient characteristic of a given subset and the coefficients obtained in the other subset. This approach essentially tests the reproducibility of the estimation of the regression coefficients. In boot-strap analysis, replicate populations are constructed by sampling with replacement from each hospital's population. These replicate populations are of equal size but differ from each other in case-mix. Regression analyses are then performed independently on each boot-strap replicate.

Rank-order (Spearman) correlation coefficients of standardized residuals, the difference between the actual and predicted mortality rates divided by the standard error of that difference, were used to compare the results of the various analyses. In addition, the reproducibility of the identification of "outliers", hospitals whose standardized residuals were above +1.96 or below -1.96, was evaluated by ascertaining what fraction of outliers found in one year were still outliers in a subsequent year and what proportion of outliers on first-occurring admissions in 1986 were also outliers when last-occurring admission were analyzed.

SUMMARY

The tabulation of the numbers of cases at risk (i.e. the number of patients whose last discharge in 1986 was from the given hospital), of the percentage of these persons who died within 30 days of the date of admission for that hospitalization, and of the range of predicted mortality rates encompassing 95% of the probable values on the logit scale forms the core of the present publication. The observed overall mortality rates of approximately 4% of the hospitals place them more than 1.96 standard errors above the rate predicted for the case-mix of the patients of that same hospital. However, this quantity is very dependent on the precise formulation of the variance. If the interhospital variance is omitted, the number of "high outliers" rises to about 11%. In contrast, the number of "high outliers" computed by means of multiple linear regression is 2.5%. However, the variance, or more precisely, the standard error appears to behave as a scale factor affecting the shape of the distribution but to have little influence on the position of a hospital relative to the others. Thus, the Spearman correlation coefficient of residuals and of standardized residuals is about 0.95, i.e., the order is determined predominantly by the residual itself, the difference between the observed and the predicted mortality rates.

The stability of the predicted mortality rates when the case-mix of the hospital is held constant is attested to by the results of cross-validation: the Spearman correlation coefficients of standardized residuals calculated from the vector of covariates and regression coefficients estimated in the same subset with standardized residuals obtained from the same vector of covariates but regression coefficients estimated in the complementary subset are 0.99 or higher for various diagnostic categories including the most heterogeneous, cancer. In contrast, the Spearman correlation coefficients of standardized residuals obtained in successive boot-strap iterations, in which the case-mix of the hospital is allowed to vary but other characteristics are implicitly held constant, lie in the range 0.6-0.7. The implication of this last, which bears importantly on year-to-year stability of rankings, is that there remain important causes of variability in outcomes associated with variations in patient characteristics (such as severity of illness) and other factors that have not been taken into account in the models used in the present analyses.

Comparison of standardized residuals obtained by logistic regression at the patient level and by linear regression at the hospital level yields Spearman correlation coefficients that lie in the range 0.92-0.99 for the specific diagnostic categories. For the overall mortality rate, the Spearman correlation coefficient is 0.83. However, in this instance the logistic and linear model are specified differently. In the

logistic model, the results for overall mortality are obtained by simple aggregation of the results of the analyses of the specific diagnostic categories, plus the category "other", whereas in the linear model the diagnostic categories are treated as covariates. A rank-order correlation coefficient of 0.89 is also obtained when overall mortality assessed by indirect standardization is compared with the results of logistic regression. Multiple linear regression gives a convenient estimate of predictive power in the proportion of the variance accounted for by the model. For last-occurring admission and specific diagnostic categories this lies in the range of a few percent to 37%, the latter applying to the category "cancer." For overall mortality, this quantity is 59%. Almost the entire (95%) predictive power of the model for overall mortality is accounted for by ten patient characteristics: age over 85, severe acute heart disease, sepsis, pulmonary disease, cancer as a comorbidity, cerebrovascular accidents, renal disease as a comorbidity, metabolic and electrolyte disturbances, severe chronic heart disease, and age between 70 and 74.

The validity and utility of the approach used herein is best tested by comparing the results of analyses of first-and last-occurring admissions in the same calendar year and of patterns observed in successive years. When comparing first-and last-occurring admissions it is important to note that about two-thirds of hospital patients have only one discharge in a given calendar year and that one-third have multiple admissions. Therefore, some correlation will be forced by the overlap of first and last-occurring admissions. The average probability of death within 30 days of a first-occurring admissions in 1986 was 6.9% and that for the last-occurring admission was 11.7%. Clearly, these hospitalizations are associated with very different risks. For 1986 discharges, the Spearman correlation coefficient of standardized residuals for first-and last-occurring admissions was 0.83. In addition, about two-thirds of the hospitals identified as high outliers for first admissions were also high outliers based on analysis of outcomes of last-occurring admissions (71% if the interhospital variance term was not used in the calculation of the standardized residual and 64% if it was).

The Spearman correlation coefficients of standardized residuals for last-occurring admissions in 1985 and 1986 were 0.61 (0.57 if the interhospital variance component is included in the variance) and 0.51 (0.48) when 1984 and 1986 rankings are compared. The concordance of high outliers in 1985 and 1986 was 48% and for 1984 and 1986 it was 44%.

☆ U.S. GOVERNMENT PRINTING OFFICE : 1987 O - 196-860 (Vol . 2)

CMS LIBRARY
3 8095 00015195 7

HCFA Pub. No. 01-002